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Commissioned to explore the relations between the Department of Health, Education, and Welfare (HEW) and state and local agencies in the field of health, the committee interviewed key HEW administrators, met with state and selected local health officials in nine states and officials of health associations, and invited comments from more than 50 professional health and welfare organizations. Government functioning is complicated by (1) diffusion of responsibility through various agencies other than HEW and within HEW through agencies other than the Public Health Service, (2) inadequate provision for coordinating the health activities of the numerous agencies, (3) further diffusion, compartmentalization, and lack of coordination at the state and local levels, (4) inadequacy of regional approaches, and (5) the shortage of qualified health manpower. Included in the 29 comprehensive recommendations for strengthening the local, state, or federal health partnership are the (1) transfer of Office of Economic Opportunity demonstration projects to HEW Administration after they have proved their Health Manpower, and (3) expansion of training programs for supporting personnel along with guidance, student aid, and eacher education programssupported by the Office of Education. (JK)

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ADVISORY COMMITTEE ON HEW Relationships WITH State Health Agencies

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE U.S.A.

Report to the Secretary

DECEMBER 30, 1966

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Advisory Committee on HEW Relationships with State Health Agencies

Report to the Secretary

December 30, 1966

DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE
WASHINGTON

Honorable John W. Gardner
Secretary of Health, Education,
and Welfare
Washington, D.C. 20201

Dear Mr. Secretary:

We are in a period of unprecedented promise for the health of the American people. Our affluence as a Nation, our growing store of scientific knowledge, and our technological capacity, coupled with a growing public demand for high-quality medical services, give promise of the attainment of unprecedented levels of health care in the United States.

Comprehensive, high-quality health services can, and should, be readily available and accessible to all Americans. Such services are provided in major part by the private practitioners of medicine. But the people of this country have demonstrated that they expect their governments to do whatever needs doing to assist, support, and supplement private practitioners. Hence, the extent to which Americans will enjoy the promise of better health depends to a considerable extent upon the effectiveness of the Federal-State-local health structure in this country.

That is why the assignment you gave to this Committee is vitally interesting, challenging, and timely. You asked that we appraise existing relationships between the Department of Health, Education, and Welfare and State health agencies. The accompanying report presents the results of our effort. It identifies the problems that exist, recommends ways of strengthening local, State, and Federal health agencies and proposes actions that will improve the relationships among these agencies.

Your objective--to strengthen the Federal-State-local partnership for health--is an eminently worthy one. We are grateful for the opportunity you have given us to assist in this endeavor.

Respectfully submitted,

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FOREWORD

The people of the United States depend for health services upon private practitioners and a wide array of institutions and agencies--public and private.

In recent years, the institutions involved have grown in number, size and complexity. They have grown because people needed the services they offer.

Individuals can be helped best if the institutions which serve them are clear as to purpose and task, are well organized, and work together effectively. If they work together in a creative manner, the health of the individual will be well served. If they do not, relationship itself can become a problem, and the health of the individual can suffer.

Almost all the constituent agencies of the Department of Health, Education, and Welfare have some health responsibilities. Together and separately, they deal with an astonishing number of agencies at the State, regional and local level. The problem of relationships among all these agencies is a huge one, calling for attention at every level of government.

That is why I called upon an Advisory Committee, headed by John J. Corson, to explore the relations between the Department and State and local agencies and to give us recommendations as to how we might improve them.

The report of this Committee contains a wealth of provocative ideas, many of which should prove useful to us in the Federal Government and to officials in State and local government. It should serve as a source of lively discussion and subsequent action.

Secretary

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CHAPTER I - TODAY'S HEALTH CHALLENGE

The Committee's Mission

The Congress has declared that --

> "Fulfillment of our national purpose depends on promoting and assuring the highest level of health attainable for every person, in an environment which contributes positively to healthful individual and family living; that attainment of this goal depends on an effective partnership, involving close intergovernmental collaboration, official and voluntary efforts, and participation of individuals and organizations; that Federal financial assistance must be directed to support the marshalling of all health resources - national, State, and local - to assure comprehensive health services of high quality for every person, but without interference with existing patterns of private professional practice of medicine, dentistry, and related healing arts."[1]

Achievement of this national purpose is, in considerable part, a responsibility of the Department of Health, Education, and Welfare and the State health agencies[2] with which the Department is associated in many ways. The relationships among these Federal and State agencies and the local health agencies in each State influence importantly --

-- the continuing assessment of the health needs of the Nation

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[1] Sec. 2 (a), PL 89-749, Comprehensive Health Planning and Public Health Services Amendments of 1966.

[2] The term "State health agencies" is used to comprehend all agencies of the State government in addition to the State health department that receive financial support from the Department of Health, Education, and Welfare (including such agencies as the mental health department, the vocational rehabilitation department, and the university medical school) and other agencies with similar health responsibilities.

-- many of the services available to supplement the efforts of private practitioners in combatting illness, disability, and death, and in improving the standards of health care for people

-- the development of health manpower and facilities to provide the needed personal and environmental health services

-- the stimulation and support of research into the causes of sickness, the relationship of man to his environment, the application of new knowledge, and the delivery of health services

-- the financing of the medical and hospital care available for a considerable portion of the population.

This report assesses those relationships and suggests ways of improving the effectiveness of Federal-State efforts in health. It is the report of an Advisory Committee created by John W. Gardner, Secretary of Health, Education, and Welfare to:

1. Examine the nature of the existing relationship between the Department of Health, Education, and Welfare and the State health agencies.
2. Identify the problems which exist and recommend proposals for their solution, taking into account the needs of local, State, and Federal agencies.
3. Recommend ways of improving the relationships between the Department of Health, Education, and Welfare and State health agencies in the interest of better health for the American people.

The Committee's Approach

The Committee interpreted its assignment broadly. It viewed the health effort as the totality of personal and environmental services, provided on an individual basis or in community programs.[1] Thus, the public concern with health comprehends preventive, diagnostic, therapeutic, and rehabilitative care of physical and mental illness. It includes personal health services, whether provided in the home, physician's office, hospital, clinic, health department, work place, or school; and community environmental services, whether provided at a public eating place, waste treatment plant, sanitary landfill, or by a local housing and urban renewal authority or regional planning agency. And it includes services paid for by the individual himself, directly, through insurance, by public funds, or in his behalf by private agencies.

To learn the nature and the strengths and weaknesses of the prevailing relationships between the Department of Health, Education, and Welfare and the State health agencies, the Committee sought advice and counsel from a variety of sources. It interviewed key Federal administrators throughout HEW, both at headquarters and in the regions; visited nine representative States, and in each met with the Governor's designee, with the chief health administrator, and with selected local health officials; met with officials of the American Public Health Association and the Association of State and Territorial Health Officers;

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[1] The Committee did not include within the scope of its study the intramural or extramural research activities of the National Institutes of Health.

and invited comments from more than fifty professional health and welfare organizations. (See Appendix for details.)

These visits, interviews, and meetings brought the Committee in contact not only with health officials but with welfare administrators, mental health authorities, rehabilitation administrators, education officials, medical school deans, consumer protection agencies, air and water pollution control officials, departments of agriculture, and chief administrative and fiscal officers of several States.

Promise for the Future

An inquiry into the effectiveness of these health relationships comes at a propitious time. This Nation's scientific and technological advance gives promise that greatly improved health services -- both personal and environmental -- can be available to the people of this country in the years immediately ahead. And the current emphasis being placed upon "Creative Federalism" makes propitious an inquiry as to how Federal and State agencies can collaborate more effectively.

a) Advance in medical technology

Major advances in drug therapy, in the eradication of communicable disease, in the development of artificial hearts and kidneys, in rehabilitation of the disabled, are examples of the benefits that an advancing technology puts in the hands of those private and public agencies upon whom the people depend for health services. The application of research over the next decade -- particularly to the aging process, cancer, chronic diseases, mental illness, and environmental hazards -- portends equally beneficial results in these areas.

New developments in computer technology make increasingly possible the use and extension of automated techniques for mass health screening, patient monitoring, medical diagnosis, laboratory procedures, record keeping, analysis of the environment, and improvement of systems for the delivery of medical care.

b) Investment in research and training

Since World War II this Nation has made an annually increasing investment in medical research and in the training of health personnel. The National Institutes of Health, the main research arm of the Public Health Service, has grown until it now conducts or supports 40 percent of this Nation's total medical research effort. Its annual investment in research has grown from $52 million in 1950 to $1.2 billion in 1966-1967. Another half billion dollars a year is now devoted to the development and training of health manpower.

c) Government assumption of responsibility

The prospect for improved health services and for the improved health of the American people is further enhanced by Government's increasing acceptance of responsibility for the people's health.

In 1940, 22 percent of all expenditures for health and medical care were met from public funds; today this proportion has grown to 26 percent; Medicare[1] and Medicaid[2] will undoubtedly raise this ratio in the decade ahead. This progressive assumption of governmental responsibility -- and the prospect for the future medical care of individuals -- was strikingly illustrated in 1966 when the State of New York decided to provide free medical care under the new Medicaid program for families of four with annual incomes up to $6,000.

This assumption of responsibility by government has been prompted by numerous factors -- to name a few: the emergence of the problems of metropolitan areas, the quest for equal opportunities for racial minorities and for the poor, and pressures to conserve our natural resources and enhance natural beauty that forced attacks upon environmental pollution. These, together with the recognized need for comprehensive health planning and less restrictive health program financing, underlay the enactment of the "Partnership in Health" Act[3] during the closing days of the 89th Congress. This legislation offers a unique beginning stimulus to the setting of new national health goals and for the planning of improved health services.

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[1] The Title XVIII of the Social Security Act-Health Insurance for the Aged, PL 89-97.

[2] Title XIX of the Social Security Act-Grants to States for Medical Assistance Programs, PL 89-97.

[3] Comprehensive Health Planning and Public Health Service Amendments of 1966, PL 89-749.

Health legislation and health programs were once looked upon as "technical" issues. Ordinary citizens were not expected to have nor believed to be qualified to voice opinions. But, of late, issues such as Medicare and pollution control have become matters of general public concern. Society has concluded that health issues are too important to be left solely in the hands of physicians or other professionals. The prospect is that proposals and programs aimed at attaining better health will increasingly be debated in the public arena and decided through the political process.

d) Growing support for the health effort

The promise of better health for the American people is reinforced by the fact that society has agreed to invest more for health maintenance and improvement. The affluent society need not, and there is increasing evidence that it will not, content itself with minimal standards for health care -- or no health care at all for the least fortunate members of society. This is manifest in the increase in both public and private expenditures for health and medical care over the past three decades. Less than $4 billion was spent for health in 1940, or only four percent of the Gross National Product in that year. In FY 1965, the total health expenditure reached an estimated $38.4 billion, about six percent of the Gross National Product, and about $200 per capita.

Public expenditures for health and medical care amounted to $10 billion in 1965. That year, for the first time in history, the Federal share of these public funds ($5.1 billion) exceeded the contribution of State and local governments ($4.9 billion). However, of the $5.1 billion Federal expenditures, over $1.1 billion was devoted to medical research and not to aiding the States and localities in providing health services. Indeed, the increase in State and local health expenditures has been greater than the increase in Federal expenditures other than the support of research during recent years. Yet as late as FY 1964 two-thirds of the States were still spending less than $3 per capita for health services.

Obstacles to Better Health

If, however, the promise of better health for all Americans is to become a reality, a number of obstacles must be overcome.

A. Urbanization generates new problems and brings with it environmental stresses.

The massive migration of population during the last two decades -- from rural to urban areas -- and the middle-class exodus from the center city to the suburbs, with a resulting concentration of low-income families in the core city -- have aggravated our health problems. Such problems as air and water pollution, noise, crowding, accidents, and poor housing have been intensified by urban growth and increasing industrialization.

A substantial number of physicians and some hospitals have moved to suburban areas. Critical health needs in the core city, as a consequence, have remained unmet. Charity hospitals and clinics -- inundated by great numbers of patients -- simply lack the resources to meet the growing demand for services. The result is suggested by the fact that in the 21 cities with populations over 500,000 only 4 had significantly lower infant mortality rates in 1963 than in 1960-1962; in most cases the trend was toward a higher rate.

B. Obsolete governmental structures make advance in the provision of health services difficult.

Today's health problems do not respect yesterday's governmental jurisdictions or structures. Despite obvious advance in health conditions and notable instances of creativity, there is still evidence at every level of government of fragmentation, duplication, and outmoded administrative and fiscal practices which waste resources and frustrate effort.

At the local level, it is common for essentially related services to be divided among separate cities, counties, boroughs, districts, and authorities which expend their resources in overlapping and uncoordinated activities. Effective planning for medical and environmental health service is all too often impeded by a parochial outlook and jealousy among local political entities.

At the State level, reapportionment has begun to shift the focus from rural to urban problems. However, archaic laws and the continued domination of State boards of health by private practitioners whose interest and attention are traditionally focused on the personal care of patients (rather than on the health problems of a community) has tended to circumscribe the freedom or desire of State health agencies to expand their services and to undertake new programs of medical care.

At the Federal level, expansion and proliferation of health programs have resulted in a tangled web of health agencies with varied goals reflected in over 100 separate financial grant-in-aid programs. Without coordination of Federal health activities and lacking the guidance of clear national health goals, this expanded Federal health effort is less productive than it can and need be.

C. An overly rigid medical care system inhibits new approaches to the provision of health services.

The medical care system in this country is organized around solo practitioners and individual hospitals. This system has contributed substantially to the high level of medical care available to most Americans. But tradition has encrusted this system with restrictions, sometimes solidified in legislation, that make difficult adaptation to new circumstances. For example, the expensive equipment and specialized support now required for the efficient practice of medicine is not logically accommodated to the solo practice of medicine. By discouraging such innovations as group medical practice and extensive use of paramedical personnel, the system tends to duplicate and waste scarce resources.

Proper utilization of medical facilities and manpower is a major factor affecting the cost and efficient delivery of medical services. Extended care facilities can provide services at a fraction of the cost at hospitals, while health care at home can be provided for a fraction of extended care facility cost.

However, little has been accomplished and much remains to be learned as to how utilization can be reviewed and controlled, even in our public medical care programs. Utilization review committees have begun to function in most of our hospitals and extended care facilities as mandated by the Medicare program, but nursing home utilization is still entirely unregulated.

D. Too little emphasis on the application of knowledge delays health advance.

Heart disease, cancer, and stroke together claimed 1.2 million lives in 1963 -- more than 7 out of 10 deaths in this country. Yet a simple screening test can detect cancer of the cervix -- now responsible for 10,000 deaths each year -- in its earliest stages when it is generally curable, and new developments in the early detection of other forms of cancer hold forth the promise of saving many lives. The same is true for other diseases -- among them diabetes, arthritis, and glaucoma.

Open dumping and open burning of garbage and refuse are prevailing practices that create health hazards even though economical and safe refuse disposal methods are available. Similarly, some 1,000 deaths are caused each year by communicable diseases against which effective immunizing agents are available. Preventable tuberculosis and venereal disease account for an additional 12,000 deaths. And, tragic episodes -- mosquito borne encephalitis in Dallas, hepatitis from the public water supply in Riverside, California, and from shellfish in New Jersey and Mississippi, botulism from smoked fish in Michigan -- still occur with costly consequences. The speed of transportation and the size of the population at risk make increasingly essential the more rapid and broader application of knowledge that now exists for the improvement of human health.

E. The shortage of manpower hampers the delivery of health care to people.

Manpower for both personal and environmental health services is in scarce supply. More doctors, nurses, engineers, and allied health workers are needed now and will be needed even more desperately in the future.

The attainment of the better health that is achievable requires the best possible utilization of the trained manpower that is available and the attraction of more of this country's talented young people in the colleges and universities to the health fields. While additional manpower is being developed in the allied medical fields, as well as in the medical, nursing, and engineering fields, the shortage of qualified manpower is destined to deny needed health care to some of our citizens and to limit the effectiveness of public health agencies, hospitals, and clinics.

F. Rising costs tend to make better health care unavailable to many people.

The costs of medical care persistently rise. Even though hospital stays tend to be shorter, spiraling wages and the costs of specialized equipment and services have boosted hospital costs sharply -- 7 to 8 percent annually over the past decade, and perhaps as much as 20 percent next year. An explosive increase is anticipated in the next few years because of salary increases to bring the level of earnings of low paid hospital workers up to a realistic status, together with an increased demand for services resulting from Medicare and Medicaid.

Meanwhile new technical developments in medicine tend to increase the cost of delivering medical services, e.g., an electrocardiograph machine costs more than a stethoscope, open heart surgery more than an appendectomy, and kidney dialysis more than any patient can reasonably afford. These factors constitute a major obstacle to the attainment of the better health care that is now available.

G. Lack of public understanding of health care and inadequacy of health services limit advance.

Much of the improvement in health over the last twenty-five years has come about because of improved standards of living, better education, and better nutrition rather than as a consequence of advance in medical science. Better knowledge about health has helped to dispel long-standing attitudes which militated against early prenatal care, dental care for children, and the like.

However, health education efforts have not been effective in reaching lower-income groups among which health problems are most aggravated. Thus, many citizens are inadequately equipped to take advantage of all available health knowledge and health services. The low scores achieved on the recently televised national health quiz are indicative of the poor knowledge of health of the average citizen and the vastness of the education task at both child and adult levels.

H. Health professionals and their associations have tended to focus narrowly on matters that may affect their own status.

Physicians, nurses, and other health professionals in their associations have tended to concentrate on their personal and financial needs to the exclusion of matters of broader concern. They have too seldom joined in common efforts to attack larger health problems.

This is robbing them of an effective voice in developing new patterns for delivering professional health services. Their active participation in a positive and creative way is essential in planning and administering new programs for providing comprehensive care, in the wider use of the allied health professions, and in critical evaluations of their own changing roles in the current health revolution.

The Next Steps

Scientific knowledge, economic affluence, public demand for better health, and government's increased acceptance of responsibility for doing what is needed, underwrite the promise of better health for all Americans. The achievement of that promise, however, requires more effective performance on the part of Federal, State, and local health agencies in the application of increased funds, greater facilities and improving technology; requires increasingly effective coordination among private and public health forces; and requires the development of new and improved systems relating facilities and manpower in more effective methods of the delivery of medical care to individuals. Money alone is not the answer; equally required is the better use of the resources now being invested.

More effective relationships among Federal, State, and local governments in the use of these resources are essential to meet today's health challenge.

Chapter II evaluates the present capability of government to meet the task ahead, and the later chapters offer our recommendations for improvement.

CHAPTER II - ASSESSING ADMINISTRATIVE CAPABILITIES

Is this country's governmental health structure equal to the task of formulating and then attaining the health goals that scientific advance and increased resources make possible? The answer is - No.

The existing structure -- consisting of the Department of Health, Education, and Welfare, and State and local health agencies -- cannot bring to reality the improved health services that are both feasible and expected.

Available evidence indicates that the rapid rise in health expenditures has not been accompanied by an efficient use of public or private resources; that health services at all levels of government are fragmented and uncoordinated; that conflicting standards, varying matching ratios, and competing programs limit the ability of financial grant-in-aid assistance; that health agencies are currently locked in a costly competition with welfare agencies and sometimes with each other; and that the scarcity and inefficient use of manpower handicap health programs at all levels.

Fragmented Organization

Diffusion throughout the Federal government -- At the Federal level the responsibilities for improving the health of the people are distributed among several departments and agencies. The resulting fragmentation of effort wastes scarce resources and does not provide clear leadership for State and local agencies.

The Department of Health, Education, and Welfare is the primary focal point of the Federal Government's health effort, and currently administers health programs involving the expenditure of some $2.6 billion. A score of other Federal agencies, however, have important health responsibilities, accounting for an additional $2.5 billion. These include the following:

Agency	FY 1967 Expenditures in million dollars	Medical and Health Related Programs
Dept. of Defense	1458	Hospital and medical care of military personnel and their dependents, retired personnel and their families and overseas civilian personnel; military health research, training and facilities construction.
Veterans Administration	1386	Hospital and medical care for veterans.
Dept. of Interior	163	Water Pollution Control Administration activities, care of Aleut Indians, grant to territories and American Samoa.
Dept. of State	143	AID and Peace Corps health assistance to underdeveloped countries, medical care of Foreign Service personnel and their dependents, international organizations, and military assistance.

Dept. of Agriculture	128	Plant and animal research and disease control, meat and poultry inspection, loans and grants for rural community water and waste disposal systems.
Atomic Energy Commission	102	Research on the effects of radiation and protection from the use of nuclear materials.
Dept. of Housing and Urban Development	87	Loans and grants to communities for sewer, water and health related facilities.
National Aeronautics and Space Administration	76	Research on health factors and human capabilities in advanced aerospace systems.
Office of Economic Opportunity	75	Development of neighborhood health centers, Head Start, Community Action programs.
National Science Foundation	36	Support of basic research in health-related fields.
Civil Service Commission	32	Government contribution for health benefits for retired employees.
Dept. of Labor	20	Hospital and medical care for Federal employees injured in line of duty, occupational health.
Dept. of Commerce	10	Small Business Administration loans for nursing homes and other health related facilities.
Dept. of Justice	8	Medical care of Federal prisoners.
Canal Zone Government	7.8	Medical and hospital care for civilian and military personnel, sanitation and quarantine.

Federal Aviation Agency	1.7	Research on health aspects of aviation.
United States Information Agency	0.4	Medical care of Foreign Service Officers abroad.

The departments of Housing and Urban Development, Interior, and Agriculture are all involved in environmental health responsibilities, as is HEW. The development of health manpower is a concern both of HEW and of the Department of Labor. The Office of Economic Opportunity administers a sizable program of health services for the poor, a fully appropriate program area for HEW also.

No truly effective means of coordinating these health activities now exists within the Federal establishment.

Diffusion within HEW -- A similar dispersion of responsibility exists within the Department of Health, Education, and Welfare. The principal agency within HEW charged with protecting and improving the health of the American people is the Public Health Service. But five other HEW constituents -- the Welfare Administration, Social Security Administration, Vocational Rehabilitation Administration, Food and Drug Administration, and Office of Education-- administer important health programs. The health activities of the Welfare Administration are carried out in two separate units -- the Children's Bureau and the Bureau of Family Services.

Each of these agencies has its own legislative authority, and employs its own program standards, criteria, fiscal formulae and administrative mechanisms in dealing with State and local agencies. They have developed separate patterns of relationships, often with the same State and local officials. They compete for the same clientele -- e.g., mothers and children, or the handicapped, while other population groups are neglected because the agencies are oriented to specific diseases, or to financial status, age, or occupation. All of the agencies compete vigorously for an insufficient number of trained doctors, dentists, nurses, and others.

Some attempts have been made recently to coordinate various HEW health activities. The Surgeon General, for example, is charged with advising the Social Security Administration on the health aspects of Medicare and the Welfare Administration on the Title XIX program of medical care for the medically indigent. With regard to the latter Medicaid program, evidence suggests this effort to coordinate health and welfare aspects is not successful because at the State level each agency strives to gain responsibility and control without changing its traditional pattern of administration. There is reluctance on the part of welfare agencies to get away from their traditional "vendor payment *gestalt*." Similarly, the Public Health Service and the Food and Drug Administration have not developed effective approaches that would interrelate their overlapping responsibilities for consumer health protection, particularly with respect to the control of food, pesticides, and biologicals.

The attempts at coordination have been piecemeal and fragmentary. For the most part, the HEW structure is so rigid as to make it difficult to develop a unified, comprehensive, national approach to meeting the health needs of all the people of the United States.

Agents for coordination -- The President has indicated that he looks to the Surgeon General of the Public Health Service for the establishment of national health goals and for providing leadership in the health field. The Assistant Secretary for Health and Scientific Affairs, who serves in a staff capacity to the Secretary of Health, Education, and Welfare, has a related responsibility. His assignment is to coordinate the health activities of various HEW agencies, and to relate these activities with the health functions of other Federal agencies.

Yet, the heads of HEW agencies -- i.e., the commissioners of Vocational Rehabilitation, Social Security, Welfare, Education, and Food and Drug -- have a stature and direct responsibility that gives them strength and independence along with their own separate paths to Congressional committees and sources of public support. For this and other reasons, neither the Surgeon General nor the Assistant Secretary separately or jointly are able to fulfill the President's expectation.[1]

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[1] One mitigating (and suggestive) factor is the circumstance that two HEW agencies--the Food and Drug Administration and the St. Elizabeths Hospital --are now headed by Public Health Service Officers on detail.

Diffusion at the State level -- The compartmentalized and ragmented Federal structure is paralleled at the State level. A partial listing of State agencies which have health responsibilities would include the following: department of health, welfare, agriculture, ducation, and vocational rehabilitation; mental health and separate mental retardation authorities; hospital construction authorities; special boards and commissions, such as those concerned with industrial accidents, alcoholism, narcotics and drugs; river and water authorities; public works agencies; and housing and planning organizations.

The health functions of State governments are distributed among many agencies and related in varying ways State by State. In a few States these activities are coordinated under an "umbrella-like" State agency. However, in most States, all or at least some of the health functions are conducted independently of each other and are unrelated. The success of States where health functions are integrated is dependent, not simply upon the establishment of a strong organizational arrangement, but also upon an accompanying and carefully determined philosophy of coordination and utilization of services, facilities, and manpower. In those few States like California, where this philosophy was implemented by an umbrella-like agency, the results appear particularly significant.

Diffusion at the local level -- The tangled web of programs that exists at both Federal and State levels perpetuates and augments lack of integration among health agencies at the local level, where services reach the people. At the local level, there are three types of fragmentation: (a) dispersal of program responsibility among various governmental agencies within a single jurisdiction, (b) dispersal of programs among jurisdictions with overlapping authority -- school districts, air pollution districts, sanitary districts and municipalities, and (c) dispersal of programs among official, private, and voluntary health agencies. Local governmental health services are, by and large, poorly organized and incomplete; hence, they tend to waste scarce resources and do not meet the citizen's need for comprehensive and continuing care.

The regional vacuum -- Some urban health problems defy solution by existing local and separate governments. These problems involve a wide range of personal and environmental health services -- water supply and pollution control, air pollution control, milk distribution, refuse disposal, medical and professional education, hospital and speciali medical facilities planning. Since these problems do not lend themselves to attack by separate local governments of limited jurisdiction, they persist in an organizational vacuum.

In contrast, consider these examples of how local governments have banded together in successful regional approaches. Interstate efforts include those of the Ohio River Sanitation Commission, Delaware River

Basin Commission, Metropolitan Washington Council of Governments; intrastate examples may be seen in the activities of the Association of Bay Area Governments (San Francisco) and the Bay Area Air Pollution Control District, the Northeastern Illinois Metropolitan Area Planning Commission, the Southeastern New York Hospital Planning Council. Regrettably, most regional efforts have been restricted to a single problem and are not multi-purpose in nature. Thus, they do not have the broad base of technical competence and support needed to plan and coordinate comprehensive health services within a regional framework.

Segmented Financial Aid

The Department of Health, Education, and Welfare now makes financial aid available to State health agencies for health through more than 100 separate grant-in-aid programs. These grants provide support for four major categories of activity: research, training, construction, and health services. The grants are of two types: formula grants, which are allotted among the States and usually require matching funds; and project grants, which are awarded to both public agencies and private nonprofit organizations, often without the requirement of matching support, and often for a limited period. More than 20 categorical grant programs support State and local government efforts in the field of public health. These include, in addition to the grant for general health purposes, grants for maternal and child health services, for crippled children's services, for cancer, heart disease, and tuberculosis control, for air pollution control, for mental health, for chronic diseases and health of the aged, and for radiological health.

Twenty years ago general health and specific disease control support grants accounted for the vast bulk of Federal financial assistance to the States for health. This has changed drastically. Today, most Federal financial assistance for health purposes supports research, training, the construction of health facilities, and the payment of medical care for low-income people. The ratio of Public Health Service grants for research and training in relation to grants for health services is now 10 to 1. In fact, less support is made available through the general health grant today (FY 1966 - $10 million) than was made available five years ago (FY 1961 - $17.9 million).

During these two decades the agencies eligible for aid have also changed. In the late 1940's most grant funds were allocated to the State health department. Today, funds are distributed among numerous State health agencies, and large support is provided for research and services by the medical schools. Funds are also channeled directly to local health agencies, bypassing the State agencies completely.

The Costs of Grant Fragmentation

Each grant program was established to meet a specific need. Each reflects a concern with and a determination that a particular health problem should receive concentrated national attention. But this multiplicity of grant programs has brought with it a diffusion of effort and complexity in administration even while it created and supported a variety of services for citizens.

The diffusion of effort among many separate programs is aggravated by the natural tendency of State agencies to employ specialized professional personnel to work with the same kinds of professional personnel in Federal agencies. The result is a lack of horizontal communication, which impedes coordination and comprehensiveness. This is accompanied by administrative confusion growing out of the need of accounting separately for funds derived from each separate grant program and the inability to shift personnel flexibly from one program to another.

The problem of coordination is also aggravated by the increasing number of separate agencies which need to be interrelated at the State and community level. At the State level, there are simultaneous paths of assistance to the health department, the welfare department, the medical school, the mental health agency, and the vocational rehabilitation agency. At the local level, there are separate and unrelated community health centers, mental health centers, mental retardation centers, maternal and child health centers, along with community hospitals and regional centers for heart disease, cancer, and stroke.

Most individuals and families make multiple use of such health services. In addition to requiring continuity of care -- prevention, diagnosis, treatment, and rehabilitation -- they must be viewed in terms of their entire environment -- social, economic, physical, and biological. The present proliferation of health agencies and centers affects all classes of the population and makes it costly and difficult, if not impossible, effectively to deliver the needed health services.

Varying Federal Administrative Standards

These several grant programs are administered in differing ways and with differing standards by the various agencies. For example, the Children's Bureau has set high standards and insisted that the State agencies conform. The Public Health Service, on the other hand, has permitted the States greater latitude in establishing their own standards and has accepted less rigorous criteria in the performance of health functions by the States.

Another problem is presented by the Federal requirement that a single State agency be responsible for administering certain programs. An outstanding example of this is the vocational rehabilitation program.

This requirement often handicaps the extent to which the State government may stimulate its departments to cooperate on health activities, since the "single State agency" must always be in charge of any joint activities.

The matching ratios -- that is, the proportion of State to Federal funds -- varies among the 100 grant programs of the Department of Health, Education, and Welfare. They are sometimes based on the attitude of the particular Congressional committee which reviews the agency's programs rather than on a rational judgment of relative need. At the least, these varying ratios cause confusion and administrative complexities for State agencies. More important, these varying ratios tend to distort the allocation of State resources. For example, States sometimes redirect their efforts in order to take advantage of the more favorable matching requirements of a particular program without regard to need or to the returns in relation to the investment of resources.

Finally, categorical financing tends to discourage or prevent planning for the interrelation of attack upon all health problems in a State. Specialized programs tend to operate apart rather than in concert with other health programs. This is oftentimes good during the experimental stages, but in later stages they should be brought back into the more comprehensive health program.

The field of mental health exemplifies these administrative problems. It needed a separate identification and special emphasis to attract the financial support and talent required to get underway. In the process of growth and development, however, it has substantially remained outside the mainstream of other health activities despite general professional agreement that the mentally ill need more comprehensive health care. Mental retardation has also developed in this fashion outside of the health framework.

New Patterns and Relationships

New channels (channels other than the Federal-State financial grant-in-aid) are emerging through which Federal support for health activities flows. These include: (a) direct Federal-metropolitan area relationships, (b) Federal-medical school-hospital relationships, and (c) Federal-regional and Federal-community relationships. These new channels have developed because of the inadequacy of the existing Federal-State-local structure to overcome the obstacles cited in Chapter I and to provide the broadened scope of health services that are now necessary and expected.

Direct Federal-metropolitan area relationships -- Today's greatest health challenge comes from the metropolitan centers. The urgent demand for assistance from the cities for aid in meeting the health problems of large low-income populations has given rise to an increased variety of relationships between Federal and local governments. Urban communities, engulfed by environmental problems, have increasingly held that Federal-State efforts were not meeting their needs. Recent Federal legislation to combat air pollution and to control solid wastes has opened additional channels of assistance from Federal agencies directly to local political subdivisions in urban areas.

The increasing Federal-local relationships grow not only out of the more apparent needs of the urban centers but out of the failure of State governments in many instances to cope effectively with the evolving needs of the large cities. State legislatures have been reluctant to deal with metropolitan problems overlapping two or more States. Reapportionment may attract a greater interest in the health problems of metropolitan areas by State legislatures, but the problems demand prompt efforts to develop and to support regional mechanisms or other cooperative ventures by which the local governments in metropolitan regions can cope with urgent problems.

Federal-medical school relationships -- The search for better means of delivering personal health services has also led to the development of new channels for Federal support. The regional medical programs for heart disease, cancer, and stroke suggest that the medical schools may become a channel through which Federal support is channeled to their affiliated hospitals and used to improve the private practice of medicine. Through this channel, the Federal Government may strive to make the new knowledge and new techniques emanating from the medical schools more promptly available to hospitals and private practitioners in local communities.

This approach has great potential for upgrading the quality of medical care provided in the local community. In its present stage of development, however, it has several deficiencies: it is limited in scope to the three categorical diseases; it tends to be oriented toward education rather than service; it is not fully coordinated with related community programs of State and local agencies; and most importantly in perhaps half of the States for which State plans have been submitted, the State health departments have played little or no part.

Federal-regional and Federal-community relationships -- Still other channels of assistance are developing in response to problems that are at the extreme ends of the spectrum of Federal-State-local relationships. At the one end, Federal-regional approaches are developing to attack problems that affect a group of States in common, such as the Appalachia development program and the river basin pollution control programs.

At the other end of the spectrum, the urgent need to directly attack the pockets of decay and blight in the slum areas of our urban centers has given rise to a direct Federal-neighborhood relationship. Between these ends of the spectrum, relationships are evolving that enable the Federal Government to work with multi-county and multi-municipal groups such as the Area Planning and Development Agencies in Georgia. Additionally, there are direct Federal relations with single jurisdictions -- cities, counties, and municipal authorities.

Thus, the Department of Housing and Urban Development has for a long time administered community-oriented programs aimed at improving the physical environment within which people live in our core cities, particularly through public housing and urban renewal. Although its projects are aimed at neighborhood improvement, they must be part of an overall, comprehensive workable program for the entire city.

OEO is the first Federal agency to adapt a health services program to this neighborhood-oriented approach through an imaginative experimental program establishing neighborhood health centers and through other community-oriented projects such as "Head Start." These OEO projects are designed to meet the needs of just one segment of the population -- the poor.

One may well ask why these two Federal agencies have been able to develop such programs, while HEW has apparently been unable to do so?

Although both of these channels, Federal-regional and Federal-neighborhood, are already well established patterns of contact, they pose difficult problems in the maintenance of effective Federal-State relations. If the State responsibility to meet these same regional and neighborhood challenges is not considered and provided for in the evolution of these new channels, the effectiveness of State efforts to meet regional and local needs may be materially weakened or even destroyed.

Weak Links in the Health Structure

In only a few States are the governmental health agencies now so organized as to provide capable leadership. In each of these States a single strong State health agency is a vital force.

Unfortunately, in most States the responsibility for administering needed health activities is dispersed among a number of independent health agencies, as well as among welfare and education agencies. The dispersal exceeds that which might be attributed to the influence of divisive categorical grants and the activities of separate Federal agencies.

The weakness of these State health agencies is also attributable to the fact that they are generally inadequately staffed. Low professional esteem and the failure of the State health agencies to become involved in the exciting social and technical developments on the frontier of government's services to people have resulted in a failure to attract an adequate supply of imaginative and talented people and a failure to seek out and find solutions for the health problems of the people. The problem is how to strengthen those State health agencies which are lacking in leadership and in staff, and which are under-financed. The problem is also how to overcome the fragmentation that destroys unity of effort.

The Insulation of Health Agencies

Much of the weakness that now obtains in most State health agencies, in addition to the diffusive and complex factors already listed, can be attributed to insulation (a) from the public needs and desires for health services and (b) from the political mainstream of State government. This insulation is due to: (1) an excessively narrow view of what public health is all about, (2) a misguided concept as to what the responsibility of public health officials is for the health care of all citizens in the community, (3) subordination of their views to agree with the opinions of organized private practitioners, and (4) the inability of public health officials to maintain the delicate balance between getting political support and protecting the health services from embroilment in partisan political struggle.

These factors have made it difficult for State health officials to feel the public pulse and to respond aggressively to public needs. This separation from public needs and desires has been reinforced in a number of States by boards of health -- usually composed of private practitioners -- interposed between the Governor and his State health officer and sometimes exercising administrative authority. A consequence of this insulation, therefore, has been the assignment of health programs of great public concern (e.g., Medicaid, mental health, mental retardation, pollution control) to more aggressive State agencies.

This insulation is further compounded by the lack of effective mechanisms for comprehensive health planning at State and community levels. As a result, there are great gaps in services and existing resources are ineffectively utilized. The resources of medical schools, hospitals, voluntary agencies, and the private sector are generally not linked into a collaborative community effort. As already noted, the categorical nature of Federal support tends to foster a segmented approach.

Many of the deficiencies cited at the State level -- fragmentation, lack of comprehensive planning, lack of aggressive leadership -- apply to local health agencies as well. Moreover, the metropolitan proliferation of local governments further aggravates the organization and delivery of health services.

The Shortage of Qualified Manpower

If problems previously cited in this chapter a[illegible] overcome,the prospect of better health for the American people will be frustrated by the shortage of well-trained health manpower. Professionally trained and skilled manpower is scarce in many segments of the American society. But the long period of training and the substantial costs of medical education make the scarcity of physicians an especially grave and difficult to solve problem. The problem of health manpower cuts across all levels of government, agencies, and programs. Shortages are chronic, with many positions unfilled or filled by inadequately trained men and women.

An even more critical problem is the inability of public health to attract from the limited supply of trained doctors, dentists, nurses, and engineers an adequate number of men and women of superior ability. A large proportion of the graduates who enter this field today are coming from the middle or lower segments of the graduating classes of the medical, nursing, and engineering schools. The Commissioned Corps system of the Public Health Service, even with the advantage of being able to offer military deferment, has a difficult time recruiting and retaining an adequate supply of professionally trained manpower.

In recent years, the salaries of Federal health officials have been increased and made more competitive with the private sector. Most State and local health agencies have not taken similar action. Because of this and the lack of challenging opportunities, these agencies are unable to attract a sufficient number of qualified, vigorous, imaginative people.

The Public Health Service, some State governments, some local agencies, and universities support a variety of programs to attract and train new people and to sharpen the skills of people now working in the field. At present, however, the total effort -- both government and university -- is insufficient to meet the growing demands for qualified people. Increased training opportunities and additional Federal funding will not relieve the problem unless substantial changes are made in personnel administration and utilization at all levels. For example, health agencies, hospitals, and private practitioners have been reluctant to utilize fully paramedical or auxiliary personnel.

From Here Forward

Our Nation is committed to the ideal of high-quality health services for every individual. In major part the achievement of this goal will depend upon the efforts of private practitioners of medicine, but, in addition, the attainment of that goal requires that the Federal Government, all of the States, and all communities shall participate effectively. After assessing public opinion and views of various levels of government, the President and the Congress should set our national goals. But it is the State and/or local health agencies that can and should render the personal and environmental health services that will bring these national goals to reality. To play their proper role, both State and local health agencies must be strong and vigorous. There must be strong partners at each level -- Federal, State, and local -- if the relationship that we are assessing is to be effective.

Hence, subsequent chapters recommend those actions that are required to strengthen each of these partners. Since the proving ground and the primary site for the ultimate delivery of health services is the local community, the following chapter recommends what needs be done to strengthen local health agencies and improve local health services.

CHAPTER III - STRENGTHENING THE LOCAL HEALTH PARTNER

The local community provides a mirror in which the effectiveness of the relationship between the Department of Health, Education, and Welfare and the State health agencies can be viewed. That mirror reveals a literal maze of poorly related health agencies -- public and private -- and a range of health services which in most communities fall short of our expectation and capability.

Private physicians engaged in solo practice or group practice and the community hospitals provide most of the personal health care available. Voluntary organizations focus attention, raise money, and provide specialized services, according to disease categories (e.g., multiple sclerosis, heart disease, and cancer) to serve particular groups (e.g., crippled children, the blind, and the aged). Labor unions and industrial firms provide still additional health services for limited segments of the population. At the same time, official local health programs are often carried out through school health agencies and welfare departments. Federally supported mental health, neighborhood health, mental retardation, and vocational rehabilitation centers are found in many communities, frequently operating apart from other local health services. In addition, Federal health installations of the Veterans Administration, Public Health Service, and the Department of Defense are scattered throughout the Nation in many communities. The Federal facilities often operate independently of other community health resources.

Sometimes hidden in this literal maze of agencies is the local health department -- the basic link in the system of services that includes the Department of Health, Education, and Welfare and extends through the State health agencies. Its task is to assess the community's health needs, identify those that are unmet, develop or stimulate the development of health services to meet those needs, and finally provide a wide variety of personal and environmental health services for the people of the community.

Together, all of these several agencies and institutions, official and voluntary, and individual practitioners do not now make available the range and quality of both personal and environmental health services that can now be provided.

Picturing Potential Health Services

Advances in science, our increasing affluence, and our national commitment to improve health now make increasingly possible in each community:

1. High quality health services -- readily available and accessible to all -- to promote positive good health, prevent disease, diagnose and treat illness promptly, and rehabilitate the disabled.

2. The opportunity for each individual to learn about and the acceptance of responsibility on his part to use wisely the services necessary for his health and the health of his family.

3. A healthful environment in the home, in the neighborhood, at work, and at play.

4. The mobilization of all community resources -- wealth, knowledge, technology, and manpower -- in a concerted effort to raise the health level of all the people.

In this chapter we recommend the steps that need to be taken if the HEW-State health agency relationship is to be effective in seeing to it that the health goals now attainable are achieved.

Local governmental units, to cope with today's health problems, must be consolidated or effectively interrelated in a joint effort, that establishes a governmental service area coterminous with the health problem area.

The effectiveness of local governments in coping with health problems is drastically limited by the simple fact that each serves too small a geographic area in many instances.

In metropolitan areas legal authority to cope with health problems is usually fragmented among many local jurisdictions. The individual jurisdictions are neither coterminous with the problem area nor with the population to be served. In most of the country, this necessitates health administration on a county rather than on a city level. But in the larger metropolitan areas, a single county usually will not encompass enough of the problem area to be effective. In those areas means are needed for coordinating health services on a multi-county or regional basis if health problems are to be dealt with effectively. Similarly, in rural areas regional organizations are needed if resources sufficient to support the provision of comprehensive health services are to be assembled.

Environmental health hazards particularly transcend the bounds of existing political jurisdictions. Air pollutants follow whatever path the wind takes them and do not honor jurisdictional borders. As a result, a multiplicity of agencies -- sanitary districts, water commissions, air pollution control departments, refuse disposal authorities -- have been established to deal with these problems. Frequently, the population base or function is so limited that they do not have adequate budget, personnel, or laboratory facilities to do an effective job. Moreover, effective management of the environment requires a comprehensive systems approach which interrelates attacks upon air, water, and land pollution throughout the entire problem shed area.

Local government health structures must be recast to permit the provision of essential health services over the problem areas. HEW should encourage the States to incorporate into their health plans now being developed under the Partnership in Health legislation the ways and means for encouraging local health units to develop regional relationships and to serve larger geographical areas.[1] Federal and State assistance should be made available to encourage the development of local health agencies authorized to draw resources from and to serve larger geographical areas. Only if such regional organization can be evolved, will effective comprehensive health planning become a reality.

Health Planning at the Local Level

A health planning council should be established to assess local needs, to hear citizens' views, and to formulate plans in all local areas sufficiently large to cope effectively with health problems.

Planning for better health is that part of our grass roots democratic process by which citizens state what they want and are willing to pay for. To be effective, however, the planning of each community must be related to the health planning of other communities that make up the relevant area and to the planning for other functions or goals. Hence, health planning may require mechanisms that effectively assemble the needs and views of a large city or a whole county or a group of counties. Increasingly, the evolution of our democratic processes incorporates mechanisms to permit citizens thus to express themselves, and assumes that planning is both feasible and desirable.

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[1] See Sec. 314 (a) Grants to States for Comprehensive State Health Planning, and Sec. 314 (b) Project Grants for Areawide Health Planning, PL 89-749.

In metropolitan areas the health plans for each community within the metropolis should be a segment of the metropolitan or regional health plan. And the health plans for the communities and for the metropolis, to be effective, should be integrated with comprehensive planning for other functions -- transportation, schools, land use, recreation, economic development, and the like.

Unless health planning is fully coordinated with other metropolitan planning activities, there is apt to be created just another local governmental body, adding to the existing confusion. To ensure that health planning is consistent with comprehensive metropolitan planning, the areawide health planning council could in fact operate under the aegis of the recognized metropolitan planning agency or council of elected officials. Cooperation and planning coordination must not merely be encouraged, it should be required. Federal legislation is moving in this direction.[1]

The product of comprehensive health planning is more than a finite master plan. Planning is a dynamic process to develop goals and strategies, to set priorities, to allocate and marshall resources towards objectives, and to evaluate accomplishments. Plans will require re-evaluation and revision in the light of evolving public policy decisions, knowledge, and accomplishment.

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[1] P.L. 89-754, "Demonstration Cities and Metropolitan Development Act of 1966," provides for coordination of Federal aid in metropolitan areas as follows:

> Sec. 204. (a) All applications made after June 30, 1967, for Federal loans or grants to assist in carrying out open-space land projects or for planning or construction of hospitals, airports, libraries, water supply and distribution facilities, sewerage facilities and waste treatment works, highways, transportation facilities, and water development and land conservation projects within any metropolitan area shall be submitted for review --
> (1) to any areawide agency which is designed to perform metropolitan or regional planning for the area within which the assistance is to be used, and which is, to the greatest practicable extent, composed of or responsible to the elected officials of a unit of areawide government or of the units of general local government within whose jurisdiction such agency is authorized to engage in such planning, and
> (2) if made by a special purpose unit of local government, to the unit or units of general local government with authority to operate in the area within which the project is to be located.

In addition, the recent solid wastes act requires conformity with the overall plan as a condition for grants under that program.

Similar to the requirements in the Partnership in Health Act for the State health planning body, the local community health planning council should include consumers of health services as well as representatives of local governmental agencies, nongovernmental organizations, and private practitioners. For interstate, intrastate, and metropolitan area planning bodies, there should also be representation from the State governments involved.

Some provision has been made in the Partnership in Health Act for Federal and State support of local health planning councils.[1] The amounts authorized will not likely be adequate (FY 1967 - $5 million; FY 1968 - $7.5 million) to support the planning we envisage. We urge that the Department seek additional support.

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[1] Sec. 314 (b) Project Grants for Areawide Health Planning states, "The Surgeon General is authorized, during the period beginning July 1, 1966, and ending June 30, 1968, to make, with the approval of the State agency administering or supervising the administration of the State plan approved under subsection (a), project grants to any other public or nonprofit private agency or organization to cover not to exceed 75 per centum of the costs of projects for developing (and from time to time revising) comprehensive regional, metropolitan area, or other local area plans for coordination of existing and planned health services, including the facilities and persons required for provision of such services; except that in the case of project grants made in any State prior to July 1, 1968, approval of such State agency shall be required only if such State has such a State plan in effect at the time of such grants. For the pruposes of carrying out this subsection, there are hereby authorized to be appropriated $5,000,000 for the fiscal year ending June 30, 1967, and $7,500,000 for the fiscal year ending June 30, 1968."

A community health plan should provide a full range of personal health services for all people and such environmental health services as are susceptible to solution on a community-wide basis; this plan should include: a system for coordinating and integrating health services, the optimum geographic distribution of facilities, the establishment of neighborhood service and comprehensive health care centers, the conduct of health education programs and experimental projects, and the application of improved methods for controlling medical costs.

The purpose of health planning is to make comprehensive health services easily accessible to all the people in the community regardless of income, race, location, or other forces.

It should be stressed that fragmented care is not only the fate of the poor. The well-to-do also go from physician to physician with no one to integrate or interpret the different procedures he is told to accept, with little or no social service to help him in necessary job adjustments, in after care at home or in an extended care facility, and in the host of problems that accompany illness.

Achievement of the envisioned goal requires the coordination of all health services, an effective integrating force, the geographical distribution of facilities, communicating health information, and the control of rising costs.

Services to be coordinated -- Mental health, mental retardation, the treatment of alcoholism, school health rehabilitative programs, housing, and pollution control -- which generally operate outside the classic public health framework -- need to be brought back into the health orbit and made part of a unified effort. And, such environmental health activities as food and drug protection, insect and rodent control, radiation protection, accident prevention, poison control, and community sanitation need to be incorporated in the community health plan. Without all of these, personal health services may be ineffective.

Accomplishment of the central purpose further requires that all resources in the community -- private physicians, clinics, neighborhood health centers, large medical centers, hospitals, diagnostic services, nursing homes, welfare, housing, and public works agencies -- form a part of a community health system. The system should make available to each local community the assistance of regional medical facilities, capable of providing for such advanced techniques as open heart surgery, kidney dialysis, and cobalt bomb therapy.

The newly passed Demonstration Cities legislation offers an outstanding opportunity for HEW, in concert with HUD, to develop and jointly fund projects designed to improve health care services and information programs in the demonstration cities. New systems of administering and of coordinating hospitals, clinics, nursing homes, nursing services, and private practitioners should be investigated.

Innovations should be stimulated; we urge that Federal support be made available to encourage research and experimentation in the design of such health systems.

The integrating force -- The National Commission on Community Health Services has stressed the need for comprehensive health services for all people and suggests that a personal physician should perform the integrating role for every individual. To achieve the goal of comprehensive health services available and accessible to all citizens, we believe that the personal physician will increasingly need assistance in the future in bringing the needed facilities and resources to bear on the health problems of his patients. This in no way deprecates the services of the physician in solo practice. This view is based on recognition of the fact that modern medical practice increasingly involves the complementary services of allied specialists using expensive and scarce equipment.

It is still possible for a particular physician or nurse to serve as family liaison and health coordinator within a health system involving neighborhood health centers, hospitals, clinics, and extended care facilities. Of course, the bulk of the population will continue to rely upon their personal physician as the integrating force and entry point into the community health care system. For an increasing number of individuals, entry into the system may be through a neighborhood health center, voluntary, union, or industrial health service or other instrument that integrates the specialized health personnel and the facilities required.

The scope of assistance that need be available and accessible to the people of each community -- if their health is to be cared for to greatest advantage -- must include those services that can aid in meeting the related social and economic problems of the family. The victim of a heart attack may need assistance in finding alternative employment and counseling for his wife as well as medical care.

Geographic distribution of facilities -- Comprehensive health care for the individual not only requires that related rehabilitative, counseling, placement, and other services be available, but that their accessibility not be limited because of their provision by separate and geographically dispersed agencies operating without knowledge of the other's involvement. Moreover, the best health care for the individual will require consideration of the entire setting, of which the individual is a part (e.g., family, job, home, recreation). For these reasons we believe that increasingly health services should be made available to individuals through neighborhood or similar centers that provide coordination with other related social services -- welfare, employment, and legal aid. These centers would be the entry points to the community health system and the forces integrating all services needed by the individual.

Two types of such centers are envisioned, (a) comprehensive health care centers and (b) neighborhood service centers containing more rudimentary services.

Neighborhood Service Centers, we hope will in the foreseeable future, be located within walking distance of most citizens of low income areas in cities. These centers should provide services ranging from information, guidance, and referral to such basic services as health screening examinations, treatment for uncomplicated illness and minor injuries, family planning, public assistance, employment service, legal advice, and opportunities for learning basic skills (e.g., how to read and write, apply for a job, homemaking). These services should be provided free -- or at appropriate charges -- to all income groups.

Such Centers could be located in a variety of places, including public housing projects, group practice units serving low-income families, labor health centers, settlement houses, neighborhood stores, and shopping centers. They would be pleasant places to come to, open weekends and some evenings, with comfortable and convenient waiting space, a rationally maintained appointment system, and overriding courtesy.

Neighborhood service centers need to be closely affiliated with other centers which provide continuing medical care -- particularly community hospitals or comprehensive health care centers.

Comprehensive Health Care Centers would provide the broader and more sophisticated services -- including preventive, diagnostic, curative, restorative, rehabilitative, long-term institutional, nursing home care, and social services -- all services needed for complete care.

Ideally, these centers would also provide home health services by sending a physician, social worker, therapist, nurse, home health aide to the homes of individuals who are too ill to receive care on an ambulatory basis but who do not require hospital or institutional care.

Through their contacts in the center and in such home visits, these representatives of health and other social services would serve as focal points for channeling community health information and for providing access to related community services. These centers too would provide services free -- or at appropriate charges -- to all income groups. For an increasing number in the population we contemplate that services will be financed under provisions of Medicaid (Title XIX).

In some areas most of these services are available but in such a disorganized fashion that those who need them have difficulty in using them; in other areas there are gaps in service which need to be filled.

A high degree of consumer involvement would be built into the system with neighborhood aides to encourage the poor to seek health services as well as to enlist volunteers to man a play room or sitter service, a simple snack bar. Staffing would take account of language and cultural barriers which interfere with communications between consumer and provider of service.

Community health information -- HEW should initiate a major program to educate the public about health; support should be made available to finance educational demonstrations aimed at communicating health information in selected metropolitan areas and rural areas of special need.

If people of this country knew more about health -- about sanitation, about the causes of disease, about preventive and early treatment techniques -- and the availability of care, we are convinced that great progress could be made. The crucial need for more effective education about health is obvious. Fortunately, this need is more than matched by available opportunities.

Educational science and technology have made a dramatic advance in recent years. This advance makes propitious imaginative action to apply this new technology to increase the public understanding of sanitation, the causes of ill health, and ways and means of attaining better health.

The Public Health Service has carried out a number of activities to facilitate State and local public education programs, including field demonstrations, consultation, loan of health educators, training courses and traineeships, the development of informational literature, visual aids, and the like. These efforts, however, have been allotted limited resources.

New opportunities for improving public understanding are provided by recent legislation. The Partnership in Health legislation can stimulate, in connection with the new emphasis on health planning, a broadened interest in and knowledge of health programs. Similarly, the cooperative arrangements among the medical centers, research institutions, hospitals, health professionals, and State and voluntary health agencies that are being induced by the regional medical programs for heart disease, cancer, and stroke can simultaneously contribute to the education of the lay public as well as to the education of health professionals.

Under the leadership of the Office of Education, public schools throughout the nation can contribute greatly to improving the health of all people. Current school programs should be improved to provide:

1. Better health instruction for students from kindergarten through twelfth grade;

2. Adult education programs to help individuals protect their own health and better understand and utilize health services in the community;

3. More remedial services to children, such as school lunches and breakfasts wherever needed;

4. Health services to all school children as part of the total community health program;

5. Increased utilization of school facilities as centers for community health programs to reach both youth and adults.

Controlling costs -- If medical care is to be accessible to all this country's citizens, the increase of costs as well as the geographical locations and quality of service must be controlled. Spiraling medical and hospital costs can and do make preventive, diagnostic, treatment, and rehabilitative services effectively inaccessible to great numbers of our population. This is especially true for the vast majority of our population who are neither wealthy nor very poor.

The National Commission on Community Health Services has recommended several actions regarding hospital costs which warrant attention and investigation: development of extended care facilities, home care programs, and other appropriate alternative (to hospital) services; cost reduction studies, such as joint purchasing and management of laundries, laboratories, drug formularies, regional planning for hospital facilities; reimbursement of full costs by insurance plans and government agencies. We endorse these recommendations and suggest, in addition, that voluntary group medical practice arrangements offer opportunities to provide a range of specialized services with lower overhead costs.

Stronger Local Health Departments

Local health departments must be strengthened -- in attitude and in competence -- to provide staff assistance, leadership, and stimulation for each Health Planning Council.

The interrelation of all local health services in a comprehensive health system -- in conception and in operation -- requires effective staff services which should be provided by the relevant local health agency. To assume this responsibility it is essential that in most instances the local health department must broaden its view and enlarge its scope to match that of the health plan and of the representation included in the planning council.

In assuming the responsibility as staff agent of the planning council, the local health department should collaborate with and obtain assistance from all related agencies in the community bearing on health problems -- vocational rehabilitation, mental health, welfare, education, and others.

Local health departments have traditionally focused their attention and their energies on a limited range of health services. They have been responsible for the control of communicable diseases, for maternal and child health services, for vital statistics, and for environmental sanitation. This latter responsibility has often been shared with local water, sewerage, housing and public works departments. Bold approaches to air and water pollution control and total waste management have been lacking, and present measures have generally failed to keep pace with pollution in our major cities. A narrow view of economic self-interest by industry and local government has contributed to this deterioration of the environment.

Local health services have primarily been directed to preventive medicine. Some limited medical care for individuals suffering from tuberculosis and venereal disease and special programs for maternal and infant care and crippled children offer major exceptions. Local health departments, in a few major cities (e.g., New York and San Francisco are able to provide health care to the indigent; but, by and large, most local health departments have had limited authority to participate in the delivery of health services to individuals. Local boards of health, usually made up primarily of private physicians, have often discouraged these departments from undertaking the provision of such services. Such discouragement, and the growth of metropolitan centers, have limited drastically the availability of adequate health services, especially in the core of our great cities and in remote rural areas.

Although the provision of better personal health services for families not now able to obtain them is emphasized, it is essential that local health departments continue their basic public health programs. Preventive, epidemiological, and immunizational activities, and the like, have contributed substantially to our improved health, and local health departments cannot afford to curtail these functions.

The local health department forms the logical agency in the community to provide leadership and staff assistance for the Community Health Planning Council. However, the local health agency must itself be provided the funds -- from local, State, and Federal sources -- and qualified personnel it requires. Too frequently salaries have been too low to attract and retain such personnel. Moreover, the narrow and limited policy focus of many local health agencies seems to frustrate and discourage those dedicated individuals that are attracted. Both of these conditions must be overcome if a vital leadership role is to be exerted by local health agencies.

Subsequently, we offer recommendations which will serve to increase the pool of qualified professional health manpower and will provide supplementary funds to pay personnel costs in local health departments. In addition we urge that HEW periodically survey and make public the levels of salaries prevalent in local health departments and emphasize the need for the provision of salaries high enough to attract qualified individuals into these departments.

State Supplementation of Local Health Effort

The State health agency should see to it that an effective planning process exists for each local community, should aid local communities in developing their plans, should develop minimum standards for the organization and operation of local health services, and should require that local public health services become operative in all parts of the State.

Federal and State, as well as local agencies, must support comprehensive community health planning. State health agencies should require the establishment of a planning body in urban centers and a community health plan as a condition for the distribution of State and Federal funds. It is essential, however, that Federal and State agencies adhere to the plan themselves once it has been adopted. Thus, grants for local health services should be made only in accordance with the approved plan.

At the present time, in a number of States, local health departments are to be found only in some parts of the State, with many counties and other geographic areas completely without organizational arrangements and personnel for the discharge of the public health function. The Committee believes that health services, like welfare services, should be operative and available in all political subdivisions of the State and that the use of Federal and State funds for local health purposes be conditioned upon this State-wide availability.

Additionally, in the past, many States have not taken responsibility for health services in large cities. They have tended to concentrate their services in the rural areas. Some State agencies have little to offer the large metropolitan areas where local health department personnel may be better qualified to solve their problems than are State health workers.

It must be emphasized that merely to establish a health department in each major political subdivision or appropriate geographic area of the State by no means assures the availability of even a minimal level of public health services. The State must assume a strong leadership role in the development of standards for the operation of local health services and for insisting upon adherence to the standards as a condition of State financial supplementation of local health efforts.

Where a State is unable or unwilling to assist in providing health services in urban areas, the urban governments should be free to deal directly with HEW.

The State health agency should assume the responsibility for the character of the health services available throughout the entire State. Hence, it should play an appropriate role in the development of public health services in urban areas. Since the vast majority of the people live in cities, that is where the bulk of the State's effort should be directed.

The States should assist local agencies through financial aid, technical consultation, laboratory services, and planning assistance. And, HEW should persistently encourage and aid the States in measuring up to these obligations.

However, where a State is unable or unwilling to assist financially in providing services in urban areas, the urban government should be free to deal directly with HEW, and the State should facilitate the direct channeling of assistance from the Federal to the local level. In the case of large metropolitan areas, if State assistance is minimal, the great bulk of relationships should be on a direct Federal-local basis.

Federal Supplementation of Local Health Effort

HEW should seek statutory authority, adequate manpower, and funds that would enable it to respond to requests from State or local governments, when they are confronted with emergencies growing out of critical unmet health care needs.

It is a well established Federal obligation to aid local communities when their populations suffer from floods, hurricanes, and droughts to the full extent of its resources. Similarly, Federal aid is provided when lives are threatened by the onset of epidemics. The need for aid to local communities can be almost as acute when their populations suffer because of a chronic lack of medical care. Such lacks of medical care were revealed by the catastrophic riots in Atlanta, in the Watts area of Los Angeles, and in San Francisco. In these instances health officials at national, regional, and State levels lacked the authority and funds to move quickly, in conjunction with the provision of other social services, to meet the need for medical care.

It is the local health agency that must assure the availability of basic health care to all citizens in all sections of their jurisdiction if the goal of comprehensive health services is to be attained. However, the lack of such care is now evident in the core areas of some of our largest cities. There are increasing evidences that the citizens in many of these areas do not have access to needed health services and that the local health agencies in some such areas are unable to meet their responsibility for assuring the availability of essential health services.

For those areas where the assurance of basic health care is beyond the capability of the local health agency, and where the State is unwilling or unable to fill the gap, direct Federal aid should be provided. This aid should take the form either of the assignment of personnel for limited periods, or the provision of facilities, or both. Upon the request of State and local health agencies, or after consultation with each, we recommend that PHS professional personnel should be made available to assist in providing essential health services. In those neighborhoods where basic health care facilities are grossly inadequate, such as the

Bedford-Stuyvesant area of Brooklyn and the Watts area of Los Angeles, Public Health Service should accept responsibility for providing health clinics and facilities for group practice; and these facilities should be staffed by Public Health Service personnel if private physicians and nurses cannot be obtained.

In responding to requests from State and local health agencies to meet such critical needs, the Regional Health Director should assist these agencies in finding solutions to problems and in developing their own capacity more effectively to meet needs on a continuing basis.

Legislation should be sought authorizing the Public Health Service, Veterans Administration, and Department of Defense to make their health facilities available on a reimbursable basis when they are not otherwise fully utilized to meet State and community needs; and further authorizing them to contract for the use of local health services for their beneficiaries where these are available.

Demonstrations should be undertaken in a few communities where Federal health installations are located to make manifest the feasibility of such reciprocal utilization of facilities.

The reciprocal use of the health facilities of Federal agencies and of local communities needs to be encouraged so that we may make maximum economic use of all existing, scarce health resources -- hospitals, clinics, and personnel. Several Federal agencies, particularly the Public Health Service, Veterans Administration, and Department of Defense have health facilities and professional manpower in many communities throughout the Nation. Most of these facilities and their staffs operate in isolation from the health facilities and programs of the communities in which they are located. Yet, in most States and many communities the scarcity of physicians, nurses, and facilities dictates that Federal health installations within the area should be considered part of the total health facilities to the extent that these facilities are not optimally utilized.

Where local health facilities are inadequate and there is space in existing Federal hospitals, we recommend that the Federal facilities be made available and provision be made for reimbursement to the relevant appropriation account to meet the costs of care. Particularly, ways should be developed to enable local communities to avail themselves of expensive services and facilities for kidney dialysis, cobalt treatment, poison control, rehabilitation, and mental health which cannot economically be duplicated. We recommend the exploration of laternative ways of establishing incentives to encourage Federal installations to participate in community health programs.

On the other hand, this is a two-way street. Federal health programs should make use of community facilities and services for providing health care to beneficiaries. Thus, if a Veterans Administration hospital is occupied with veterans who could better be cared for in their own homes or in nursing homes in their community and do not require hospitalization, this is not the optimum use of facilities. A substantial start in this direction has been made in recent legislation authorizing the Veterans Administration to purchase some health services for veterans[1] and permitting Department of Defense beneficiaries to secure health care from nongovernment facilities under certain circumstances.

Summary

It is in each of the Nation's communities that all Federal-State and local health efforts have their impact. The maximization of this impact requires more effective and more comprehensive health planning than now obtains in most communities to ensure that health services are available and readily accessible to all. Such planning is a prerequisite to the mobilization of all community health resources -- private physician, neighborhood centers, clinic, hospital, voluntary agency, nursing home, medical school, health agency, and Federal facilities where needed -- into health care systems that will make possible a total and coordinated effort to bring all resources to bear on improving the health of people.

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[1] P.L. 89-785, "Veterans Hospitalization and Medical Services Modernization Amendments of 1966."

Community health plans alone are not enough. They will bring better health services to people only when continually implemented by effective local health organizations. To be effective local health organizations must have a broader scope, encompassing the personal and environmental health of the whole community. And to be effective local health departments must accept responsibility for seeing to it that existing gaps in this broad scope of local health services are filled.

A full range of personal and environmental health services should be available for all people, rich and poor alike. The fulfillment of this goal requires many implementary steps -- a system for coordinating and integrating health services, the geographic distribution of facilities, the establishment of neighborhood health centers, the conduct of health education programs, securing additional health manpower and holding down medical care costs.

Proper utilization of existing health facilities and manpower could help meet many health needs now being neglected and could simplify the task of planning. All health resources, from Federal health facilities to private physicians in solo practice, should supplement each other in meeting the community health needs.

The health services now available to many Americans falls short of what is clearly attainable. Much can be done within each community to ensure the full utilization of existing facilities and resources to overcome prevailing deficiencies. But there remains the need -- and the opportunity -- for both Federal and State governments to aid. In the chapter that follows the steps that need to be taken to improve the capability of State health agencies to play their part in the Federal-State-local partnership are detailed.

CHAPTER IV - STRENGTHENING THE STATE HEALTH PARTNER

If the people of each State are to enjoy a full range of health services, the health agencies in many States, even as the health agencies in many communities, must be strengthened and the deficiencies noted in Chapter II must be corrected. This chapter contains recommendations to accomplish that end.

Goals of State Health Services

The minimum goal of a State health department might well be to ensure:

1. The availability of comprehensive health services for the people of every section and every community within the State.
2. An increasingly healthful environment that will contribute to human well-being.
3. A system of manpower development, including opportunities for continuing education, that will produce an increasing number of professionally trained men and women to provide health services.
4. The continuing development of new knowledge on the causes and cures of illness and on the means of delivering health services to all the people.
5. A health education program to help all our citizens to understand the rudiments of personal health care and to learn how to use available health services effectively.
6. The coordinated effort of all health agencies -- public and private -- along with medical schools, hospitals, and private practitioners, in providing a level of health services not previously envisioned.

Comprehensive State Health Planning

Each State should formulate health objectives and carry out comprehensive planning for health services to meet the needs of all its people. The health objectives should be considered by the Governor and submitted to the Legislature for approval and enunciation as a declaration of State health policy.

There has been some good planning in connection with health activities -- for example, hospital construction, mental health, and certain environmental health programs. In general, however, State health planning has been piecemeal and uncoordinated. Several types of resources within the State -- medical and professional schools, hospitals, voluntary agencies, and private institutions -- have not been effectively involved in the essential, continuing State health planning process.

The Partnership in Health legislation offers an unprecedented opportunity for developing more comprehensive planning for health services than have been available heretofore.[1] It will enable the

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[1] Sec. 314 (a) (1) of PL 89-749 Grants to States for Comprehensive State Health Planning: "In order to assist the States in comprehensive and continuing planning for their current and future health needs, the Surgeon General is authorized during the period beginning July 1, 1966, and ending June 30, 1968, to make grants to States which have submitted, and had approved by the Surgeon General, State plans for comprehensive State health planning. For the purposes of carrying out this subsection, there are hereby authorized to be appropriated $2,500,000 for the fiscal year ending June 30, 1967, and $5,000,000 for the fiscal year ending June 30, 1968."

States through grants to set their own health goals, and help them to coordinate functions now fragmented by the multiplicity of grant programs and to correct deficiencies and imbalances in the services now being provided.

The Committee is hopeful that the States will take advantage of this opportunity and use it creatively to appraise health needs and resources throughout the State and to formulate comprehensive plans for health services that will:

1. Set immediate and long-range health goals and establish priorities for meeting those goals.
2. Provide for the needs of all the people, including but not limited to such special target groups such as mothers, children, and the handicapped.
3. Extend to all the health programs and resources -- private as well as public -- within the State.
4. Indicate how comprehensive local health services will be provided in all geographical areas of the State and describe how the plans are to be implemented.
5. Provide for the interrelation of health and related educational and social services.
6. Provide the means and methodology for Statewide data collection systems to assess and disseminate information on health needs within the State.
7. Appraise physical facilities and ensure their maximum utilization.

8. Assess manpower requirements and develop methods of overcoming shortage including provision for the full use of allied health personnel.

9. Present a financial plan for State and local services, including Federal participation.

10. Initiate and integrate demonstration and pilot programs and research projects for the better delivery of health services into the total program.

11. Permit flexibility to meet the varying needs of different localities, changing needs over time, and to cope with human disasters as they arise.

12. Encourage local health planning and provide for its implementation.

13. Assess existing legislation to determine the extent to which it encourages or inhibits advance in health and the ability to carry out the plan.

14. Strengthen the planning evaluation and service capacities of the participants.

Federal Stimulus to State Health Planning

The Congress has determined that the Federal government will provide assistance to States to develop better State health planning. To make such a proviso effective:

The Department of Health, Education, and Welfare should develop national health goals, and within the limitations of these broad goals should allow the States maximum flexibility to develop their health plans;

once such health plan is in effect, HEW should require conformity with the established objectives and priorities as a condition to the receipt of both health services and facilities grants.

HEW should establish and incorporate within such guidelines a minimum workable program for environmental and personal health services within a State. These guidelines should be revised periodically so that health services will continue to be upgraded. The Children's Bureau has used a similar technique in the past and is to be commended for the firm stand it has taken on performance standards and the improvement in the quality of health services it has stimulated in the States. Now with the new provision of a block-type formula grant under PL 89-749, the need for standards and their enforcement become all the greater. Without requiring high standards of performance, the result could be less effective services than are currently available.

Health Planning Council

A State health planning council should be established in each State to help set goals, plan programs, determine priorities, and allocate resources, including interrelation of programs for hospital construction; heart, cancer and stroke; mental health and retardation; and other relevant activities.

The interest of many agencies and institutions, both public and private, must be considered in devising comprehensive plans of State health services. All the agencies and institutions involved in the health effort must be heard in the planning process.

One of the better ways to ensure this involvement is through the establishment of a strong State health planning council which is broadly representative. The health planning council created under PL 89-749, must have broad enough scope to enable interrelationship of all health agencies and community forces. All other councils and commissions dealing with health matters (for example, regional medical programs and hospital construction) shall be expected to take into account and be guided by the judgments of the State health planning council, accommodating as necessary to interstate and regional considerations.

The organizational location of the council should remain flexible. Since the council will comprehend such highly fragmented activities, it should be an advisory body to the Governor. The Governor should approve the plan formulated by the council and we hope will be guided by it in his allocation of resources.

Strong Health Departments

There should be a strong health department capable of giving leadership and direction to the total health effort in each State. Model legislation should be prepared to guide States in developing such departments.

The State health department is the organizational entity around which a strong health effort should be built. Its mission is to achieve the highest attainable level of health and to ensure that necessary health services are provided for all persons throughout the State.

In effect, the State health agency should envision its responsibility as encompassing all the activities that are related to health. While it certainly will not provide all the health services included in the plan, the health department should play a leadership role in the total effort and should have responsibility for formulating plans to allocate resources among all tax-supported health agencies for presentation to the State health planning council. In order to do so, State health agencies must broaden their concept of "public health," especially to encompass their involvement in meeting the personal health problems of individuals, and, they must become a part of the mainstream of the political process in the State.

The State health agency should be capable of working with and giving leadership to all local agencies as well as areawide agencies where they have been established. It should move toward assumption of an active role in all direct Federal-local health relationships so that these activities can be incorporated into the total State plan.

We believe the American Public Health Association, in collaboration with the Council of State Governments, could render a valuable service by studying the statutory framework in which State health departments operate and developing model legislation for State health organization. Such legislation should define the relationships among the Governor, the State health officer, the State board of health, and health department and define the functions and responsibilities of each.

Planning Unit in Health Department

The growing demands of health programs make it essential that a permanent and well financed planning, development, and evaluation unit be an integral part of the State health department.

With the rapid changes coming in the diagnosis and treatment of disease, with the additional Federal funds being made available for health services, and with the need to improve the health delivery system, a special unit is necessary for improved planning and performance.

Along with health planning, it would also engage in activities to assure: (a) that the effectiveness of various health activities be measured, (b) that alternate ways of delivery services be tested, (c) that new approaches be conceived and evaluated, and (d) that the results of its studies and evaluations be applied as widely and as soon as possible. The Federal government should participate in the financing of such units.

Responsible Health Officer

There should be a responsible State health officer appointed by and serving at the pleasure of the Governor in each State.

In order to develop a strong focus for leadership at the State level, authority and responsibility should be vested in the State health officer. This official should be the principal health advisor to the Governor, and the Governor's representative on health matters to the legislature. Otherwise, the health department runs the risk of becoming insulated from public opinion and concern, and thereby being less effective in marshalling political and financial support for vital programs.

This insulation has often existed, most notably where State boards of health have been interposed between the health officer and the Governor and have had the responsibility for setting health policy. The board should have no administrative or policy-making functions. It should advise the State health officer as to health needs and as to gaps in presently available health services; it should marshall public support for health programs; and it should review all proposed health regulations.

If the State health agency is to be responsive to emerging needs for health services, particularly in metropolitan centers and is to exploit the increased popular support for governmental health programs, it must be effectively related to all groups in the community. This dictates the reorganization of those State boards of health that are made up largely or solely of private practitioners. The majority of the members of State boards of health should be from the general public

A Broader Partnership

State health agencies should broaden their partnership with all the health resources in the State, including medical and other professional schools; a wide variety of groups should be involved in State health planning and in developing a comprehensive system of personal and environmental health services.

The changing nature of the national causes of death and disability, new sources of funds (public and private) to pay for personal health services, the continuing growth of medical specialization, automation, population increases, rapid growth of scientific knowledge, and an increasing public interest in health are all putting pressure on existing systems for delivery of medical care. There is a general awareness of the great increase in medical knowledge. There is much less awareness, however, that modern technology and sophisticated methods of diagnosis and treatment make our existing systems of health care anachronistic. These systems are ill-adapted to make adequate use of available methods and techniques. A revolution in health delivery systems is called for; the situation demands innovation, wider use of allied health personnel, new channels of cooperative effort, and new partnerships. The State health department should be the focal point for these changes.

The development of comprehensive State health planning depends on the participation of many agencies and institutions. It is necessary for State health departments to work more closely than ever before with medical schools, hospitals, and private practitioners in developing an adequate system of personal health services. Likewise they must work more closely with natural resources, pollution control, public works,and agriculture agencies in developing an adequate system of environmental health services. The State health department should widen and deepen its partnership with all these agencies. The problems of involving these diverse groups are many. Asking for comments from them serves not only to elicit support but guides their thinking to seek new horizons.

Private physicians, as part of the total health care system, need to learn more of the many problems involved and participate in planning. Medical schools too seem destined to become increasingly involved in the delivery of community health services. They are already beginning to do so through the regional programs for heart disease, cancer, and stroke. This is a desirable trend for it can lead to more rapid and widespread application of new knowledge and to improved quality of care.

To ensure a closer liaison between health departments and medical schools, State health plans should bear the comments of the Dean of the medical school (s) or other organization operating the heart, cancer, and stroke program within the State and similar proposals submitted to the Federal government for regional medical programs for heart, cancer and stroke should bear the comments of the State health officer (s).

The Health-Welfare Team

HEW should seek amendment to the Medicaid program (Title XIX) to make the State health agency responsible for the health aspects of this program (health goals, scope of medical benefits, standards, relationships with providers of health care, utilization control, and evaluation).

The health aspects of the Title XIX program should be the responsibility of a strengthened State health agency. By "health aspects," we mean the:

1. Determination of specific health goals (e.g., reducing the infant mortality rate among the assisted population to the level of the general population).
2. Establishment of the scope of medical benefits (diagnostic services, drugs, etc.) to be provided.
3. Setting of standards for services, including hospital and nursing home care.

4. Conduct of relationships with doctors, dentists, nurses, hospitals, nursing homes, insurance companies, and other providers of health services.

5. Utilization control of health facilities and services.

6. Continual evaluation of the health care being provided, and periodic reporting to the State health planning council and the State welfare agency.

Simultaneously the State welfare agency should be responsible for:

1. Formulation of the social goals of the program.

2. Determination of eligibility.

3. Determination of needed social services.

4. Conduct of financial relationships.

In recent years, government has assumed a significant new responsibility -- the financing of personal health care for a sizeable portion of the population. An outstanding example of this responsibility is the Title XIX Medicaid program. The struggle between State health and welfare agencies for responsibilities under this program has created friction and competition where there should be complementary action and unity of purpose.

Conflict can be minimized if there is mutually accepted clear understanding of the roles of health and welfare agencies in medical care. In this connection, it may be worthwhile to examine the structure in California where a strong health department operates within the organizational framework of a combined health and welfare agency.

Single State Agency Concept

The "single State agency" requirement should be modified in order to allow States to combine the skills and resources of several agencies into a coordinated State effort, subject to the approval of the alternate arrangement by the Secretary of HEW.

The scope of public health is infinitely broader than it was a quarter of a century ago. It is inextricably intermingled with social, rehabilitative, and educational services in the provision of preventive and therapeutic care; and with sanitation, public works, and community planning in the provision of environmental health services. It is essential that State health departments work with and share with other State agencies in the achievement of what are not only health but community goals. It must not be denied the opportunity to develop imaginative and unprecedented collaborative approaches. At present, however, its hands are often tied by the requirement that a single State agency be responsible for the administration of a particular program.

The concept of a sole, or single, State agency was developed in the 1930's in an attempt to provide for equitable treatment on a State-wide basis and to provide a fixed point of responsibility in the State for the administration of a program for which Federal funds were being made available. This was necessary in the formative years of grant programs. The concept sometimes presents barriers to State efforts to meet the needs of individuals through joint projects and ventures. Under this requirement, for example, State agencies find it difficult to pool their resources, funds, and staffs, and to share responsibility in the decision-making process. The result is fragmented services and artifical bureaucratic decisions which dilute the quantity and quality of services and prevent the States from attaining the objectives they are trying to reach under the comprehensive State health plan.

The changing characteristics of the population and the mounting pressures for integrated services at the community level emphasize the problems of coordination and programming so as to provide services where the people are, when they first need them, and in the manner in which they will be most effective.

Although administration by a single State agency will most often still be the method of first choice, a more liberalized interpretation is needed to allow sufficient administrative flexibility to cut across program lines. State agencies should be free to deal with special needs and emergencies through a variety of organizational arrangements.

Interstate Arrangements and Federal Support Thereof

The Governors and their health agencies should initiate and negotiate interstate compacts and other cooperative arrangements with neighboring States in order that effective action may be brought to bear upon health problems affecting interstate areas. HEW should encourage such interstate cooperation and render financial support to the health programs of interstate agencies. Legislation should be sought from the Congress granting advanced consent to interstate compacts for the purpose of public health planning and health education.

Previously it has been pointed out that many health problems can not be contained within local jurisdictional boundaries and require regional solution. Often the region involved encompasses all or portions of two or more States. This is particularly the case in many of our metropolitan areas and in most major river basins. Thus interstate compact agencies (such as the Ohio River Sanitation Commission) and other cooperative arrangements (such as the Metropolitan Washington Council of Governments) have evolved to fill the need.

Such interstate cooperation should be fully extended to the health field and encouraged by HEW through financial support.

SUMMARY

A strong State partner is a vital link in the Federal-State-local system of health services. The State partner must be strengthened in order to improve the relationships between the Department of Health, Education, and Welfare and State health agencies. There should be a comprehensive State plan for health services, organized around a strengthened health agency. A State health planning council is essential in order to involve other official agencies, medical schools, private and voluntary resources in the comprehensive plan. The State health program should be directed by a State health officer who is responsible to the Governor. There should be an effective health and welfare partnership with clearly delineated responsibilities.

The Federal Government should stimulate and support all of these actions designed to strengthen State health agencies, to promote a coordinated and comprehensive State plan for health services and to support interstate cooperation. How the Federal partner can improve its own organizational and administrative mechanism, and provide national health leadership is the subject of the next chapter.

CHAPTER V - STRENGTHENING THE FEDERAL HEALTH PARTNER

The bulk of health services for the people are provided locally. State agencies support and supplement these services and plan comprehensive State-wide efforts. The Federal partner should play a role of national leadership in all of these activities, primarily through the Department of Health, Education, and Welfare. This Department should:

1. Formulate national health goals for the consideration of the President and the Congress.

2. Provide national leadership to reach those goals, including the planning of health programs, the development and allocation of resources and the evaluation of accomplishments.

3. Assist in carrying out plans through the design and financial support of programs for the delivery of personal and environmental health services.

4. Realign its internal organization to minimize confusion, conflict, and competition among programs and agencies for which it is responsible.

5. Encourage innovative approaches and administrative flexibility in meeting needs.

6. Expand and ensure the effectiveness of efforts to meet the increasing manpower needs of the Nation.

This chapter outlines the actions needed to strengthen the Department of Health, Education, and Welfare to meet these expectations.

Setting National Health Goals

The Department of Health, Education, and Welfare must develop its capability for formulating national health goals specific in nature, clear in statement, and including a plan of sequential steps and a schedule to guide implementation; these goals should be considered by the President and submitted to the Congress for approval and enunciation as a declaration of National health policy.

Such health goals for the Nation as are now stated from time to time by various Federal officials are piecemeal in nature, vague in statement, uneconomic in their failure to allocate scarce resources among competing demands for services, and ineffective in providing guidance to the total national health effort.

Within the Department, the Public Health Service should be equipped to develop (with the aid of State and local governments) a coherent set of such goals and plans for improving the health of every person in our society. This formulation should serve as the basis for the President's submission to the Congress of proposed national health goals and policies and for subsequent action by the Congress to set forth a national health policy in statutory form. The legislative program and budget for health should provide the Department with authority and resources to achieve the stated goals. An amendment to the "Partnership in Health" bill which was deleted before final passage, would have called upon the Surgeon General to develop National health goals.

The final "Partnership in Health" legislation does serve, however, as a first step toward the establishment of a continuing health planning process. And it surely provides the opportunity for local, State, and Federal agencies to strengthen their health partnership. We urge that it be utilized to establish truly comprehensive health planning in each State and locality.

Planning to Attain Goals

National health planning is the responsibility of HEW. To be effective such national health planning must be coordinated with planning for housing, education, welfare, employment, and recreation and with planning for the overall social, economic, and physical development of each community, each State, and the Nation as a whole.

To ensure that the needs of people in every section of the country are met effectively, State and local governments must play appropriate roles. HEW should provide the initiative and the leadership that will manifest itself in national guidelines and should make available to the States essential technical knowledge and skills. In addition, HEW, through the Public Health Service, should develop a greater capability for helping the State and local governments to do health planning and to coordinate their efforts with the private sector.

One illustrative opportunity is afforded by the regional medical programs for heart, cancer, and stroke now being established. The areawide planning efforts of the regional heart, cancer, and stroke programs to improve quality of health services through actions by medical schools, universities, research institutes, training centers, and laboratories complement the planning provisions of the Partnership in Health Act and should be coordinated.

Similarly, planning for the vocational rehabilitation, maternal and child health, mental health, and other health activities of the Department of Health, Education, and Welfare should be encompassed in the planning by each State and locality. Such coordinated planning would then be supplemented by the provisions in the Act for interagency and intergovernmental collaboration and for the exchange of personnel; such collaboration should improve health planning by integrating the contributions of the mental health, mental retardation, vocational rehabilitation, recreation, housing, physical planning, and other agencies.

Applying the New Health Knowledge

HEW should provide ample resources for research and stimulate demonstrations to devise new systems and methods for the delivery of health services to people.

The Federal Government has made a large investment in basic health research over the post World War II years. This research has produced valuable new knowledge. It has materially advanced our ability to prevent and to treat disease. It has expanded our understanding of the effect of environment on health and has increased our ability to control environmental hazards. This investment in basic health research has paid large dividends and must be continued.

The translation of research findings into action programs that improve the health of people, however, has lagged. The need now is for greater effort to find ways to apply these findings to disease protection, environmental control, and the delivery of health services. This will require discovery of better and more effective means for the delivery of comprehensive health services to people and the communication of research findings to professionals who can put them into practical use. It will also involve massive and imaginative efforts to educate the populace on health matters, particularly with regard to maintaining personal health.

Focusing Health Leadership

A stronger and better integrated organizational focus for health activities of the Federal Government must be created; this should take the form of a subsidiary "Department of Health" within the Department of Health, Education, and Welfare.

The effectiveness of collaborative Federal-State-local efforts in health can be increased through better organization and practices at the State and local levels. But achievement in each community of the level of health services -- personal and environmental -- that is now attainable will require better coordinated leadership at the Federal level.

Planning for efficient use of health resources for the focusing of national health efforts and to strengthen and guide State and local health agencies requires realignment of health agencies and health programs now located within the Department of Health, Education, and Welfare. A greater integration than now obtains must be effected if critical needs are to be met with respect to personal health and environmental health services. By better articulating the several health programs, relative health needs and priorities can be appraised and balanced, legislation and budgets can be better developed to meet our health goals, and relationships with State and local health agencies can be greatly clarified.

What organizational form should such a national organizational focus for health activities take? Health programs are intimately involved at the family level with other social factors -- education, economic opportunity, and welfare. We have recommended that such activities be associated at the community level. This is an association that should be continued and amplified at the Federal level.

There is need within the Federal Government for the association of such activities under a cabinet officer who will, for the President, weigh competing demands and maintain a balanced effort among health, education, and welfare programs (e.g., services for selective service rejectees, compared with services for school "dropouts," compared with income for retired aged) in terms of all that is currently known of the needs of American families. Hence, creation of a separate "Department of Health" reporting to the President, is we believe unwise, and indeed runs counter to the evolving recognition of the need for greater interrelation of health and other social services.

What is needed is the creation of a subsidiary department or "administration" of health within a Department of Health, Education, and Welfare that relates all health activities in a better integrated effort to marshall available economic and technical resources with equally available political and social support to cope with the pressing problems of today -- how to provide improved personal health services and environmental health services for all citizens.

The need will best be met by the establishment of a separate subsidiary "Department of Health" headed by a subcabinet secretary reporting directly to the Secretary of Health, Education, and Welfare. Recognizing that many factors must influence the assignment of functions within HEW and among its subsidiary departments, the Committee believes, from the standpoint of intergovernmental relations in the field of health, that the following activities should be brought together in the Department of Health:

(1) The Public Health Service

(2) Maternal and Child Health and Crippled Children's Programs of the Children's Bureau

(3) Health aspects of Title XVIII (Medicare) and Title XIX (Medicaid) of the Social Security Act

(4) The Vocational Rehabilitation Administration

(5) School health programs of the Office of Education

(6) Environmental health functions of the Food and Drug Administration.

Research should be intimately associated with programs for service in a mission-oriented organization.

Increased Emphasis on Environmental Health

Within the proposed subsidiary Department of Health, greater provision should be made for leadership and for funding in the field of environmental health than is now apparent.

While there are many important national health needs to be met, we are particularly concerned about the increasing environmental problems. Until recently, environmental health activities seem to have been largely submerged within the HEW organization. We are from the standpoint of intergovernmental relations in the field of health, that the following activities should be brought together in the Department of Health:

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While there are many important national health needs to be met, we are particularly concerned about the increasing environmental problems. Until recently, environmental health activities seem to have been largely submerged within the HEW organization. We are much encouraged by the steps that have been taken in the reorganization of the Public Health Service to give greater organizational stature and status to environmental health activities. The creation of a center for urban and industrial health seems a forward moving step which, with adequate funding, can serve to extend environmental health knowledge down to State and local levels.

Until recent years, environmental health activities (except for support for occupational health for a short period of time) at State and local levels have not shared in the categorical funding accorded many diseases (tuberculosis, venereal disease, mental illness) and special populations (children, mothers). Over the last ten years, actual expenditures for environmental health (excluding water pollution) were on the order of only 10 percent or less of the PHS assistance to State programs. The end result in a period of industrial and urban expansion has been that environmental hazards have multiplied faster than they have been contained.

More coordination is needed at the Federal level. At the State level, environmental health activities are generally coordinated by and focused in the State health department. But, when the State agency looks toward the Federal Government for guidance and leadership in environmental health, it finds this activity fragmented, diffused, and submerged among disparate Federal departments and their subordinate agencies.

Within HEW, responsibilities in the areas of food, drugs, and pesticides are shared between PHS and FDA. Studies are now underway to resolve the areas of overlap. With regard to environmental activities located in other departments, HEW should be responsible for health aspects of environmental problems (e.g., housing, water pollution, transportation, land use) and should provide guidance and leadership to other Federal agencies that are responsible for the administration of these programs.

Coordinating Federal Health Activities

A Federal Interagency Health Council should be established to better coordinate health activities among Federal agencies; the Council should consist of the head (or deputy head) of each of the agencies with sizable health programs and should meet regularly under the chairmanship of the proposed new Secretary of Health.

It was noted earlier that additional medical and health related programs are scattered throughout the Federal establishment in a score of agencies, including the Department of Defense, Interior, State, Agriculture, Housing and Urban Development, Labor, Commerce, and Justice; the Veterans Administration; Atomic Energy Commission; National Aeronautics and Space Administration; Office of Economic Opportunity; National Science Foundation; Civil Service Commission; Canal Zone Government; Federal Aviation Agency; and the United States Information Agency.

The activities of these various agencies should be included in the formulation of national health goals and their operations coordinated under Department of Health leadership. The Bureau of the Budget can assist in this coordination through the wise allocation of Federal resources. But the more positive and continued coordination of these Federal activities in their impact on families and on communities should be performed by the proposed Department of Health. In the long run, the economic utilization of resources and the attainment of a maximum benefit for the American society dictates that there should be more frequent interchange among the agencies and greater collaboration in the use of resources and in coping with key problems.

Although the Committee believes that considerable consolidation of health activities conducted outside of HEW could be feasibly carried out, it has only had time to study the health role of the Office of Economic Opportunity in sufficient detail to present a recommendation.

OEO Health Demonstration Projects

OEO health demonstration projects should be transferred to HEW administration after they have proven their worth by three to five years of successful operation.

In absorbing OEO projects, HEW must assure the provision of an organizational setting and a freedom which while providing support will retain the innovative qualities that they have demonstrated.

Uninhibited by tradition and dedicated to innovation and action, the OEO has made a significant, though limited, contribution to the total offering of public health services in the United States. It now provides health services through the establishment of "neighborhood health centers," through "Operation Headstart," and other health programs.

However, OEO was created to act as a catalyst, to stimulate experimentation and innovation by local, public, and private agencies (and by OEO itself) in developing new ways of attacking the complex problems of poverty. It will continue to serve this central purpose only if it does not become weighted down in the administration of programs which were once new and innovative but have become established and accepted. It is important too that these new health projects and programs become an integral part of the comprehensive health care system.

The transfer of tested and proven OEO health projects to HEW contributes strength to these projects, assures their acceptance into the health care system, places operating responsibility in an experienced health services organization and should have a stimulating effect upon that organization.

Strengthening Regional Offices

HEW should take steps to develop stronger Regional Offices. Substantially greater authority for coordination and decision making should be delegated to the HEW Regional Directors; each Regional Director in turn should be able to depend upon specialists for assistance in the direction and coordination of activities within each region.

Previous attempts to revamp and to strengthen the regional offices of this and of other departments have not been marked by notable success. Yet we believe this objective -- stronger regional offices to relate HEW more effectively to State and local governments -- is sound.

The Surgeon General has indicated his intent to delegate to the Regional Health Director responsibility for grants management and authority to approve State plans under the "Partnership in Health Act," and his intent to assign personnel to regional offices to carry out these delegations. This is an encouraging development, and one which should materially aid in coordinating Federal and State efforts to meet health needs. The Regional Director, however, needs to be intimately involved in all HEW relations with States in order effectively to relate health, education, and social welfare services to each other and to the total needs of the States (especially to meet problems requiring concerted action). The Regional Director, in arriving at decisions, will of course be expected to counsel with and utilize the technical staff available to him in each field within the regional office.

Hence, we recommend that the following steps be taken:

(1) Authority for the approval or disapproval of comprehensive State health plans, and amendments to such plans, be delegated to the Regional Directors, with the proviso that State governments can appeal adverse decisions to the Secretary of HEW.

(2) Greater authority to effect coordination among related programs at the regional level, including authority to employ and reassign personnel within the region, be delegated to Regional Directors.

(3) A firm practice be initiated by the Secretary of HEW that neither he nor the commissioners of HEW agencies will act on requests from State or local governmental officials without consulting with the Regional Director.

(4) The Regional Director be directed to plan and make regular visits with the Governors and with the mayors of major cities to discuss relevant HEW activities, including health matters, so that the Governors and mayors may develop fuller confidence in the Regional Directors, and may be expected to deal with them first more often than in the past.

(5) Contingency funds be provided so that each Regional Director (without approval of specific actions at headquarters) may assist States in emergencies and may stimulate innovative projects.

(6) The FDA districts be realigned to relate better to other health activities and to function under the HEW Regional Director, insofar as that is practicable.

Simplifying Grants Administration

Prevailing practices for the administration of grants to the States must be simplified and made more flexible to reduce in the future the confusion and distortion of programs caused by the wide variations in these ratios.

An opportunity to correct some of the deficiencies in grants administration is provided by the new "Partnership in Health Act" which addresses itself in part to the problem of categorical financing and program fragmentation. Under this legislation most PHS categorical grants are eliminated and consolidated into one block grant for health services. However, certain categorical grants of the Public Health Service and all of the grant programs administered by the Children's Bureau, Vocational Rehabilitation Administration, and the Office of Education are unaffected. Until the new concept is further extended, many of the problems cited earlier can be expected to persist.

If financial grants are to stimulate and aid the States to provide a wider range and quality of health services, formulas must take into account State variations in per capita income, in population, and in the intensity of problems. It is also appropriate to maintain additional flexibility so as to allow greater emphasis for newly developing programs, innovative approaches, and critical problem areas. However, grant inducements should not be allowed to cause or force the State governments to distribute their resources to maximize Federal funds they obtain rather than to distribute their resources consistent with the urgency of the needs for services within the State.

The haphazardly varying ratios among programs -- sometimes 1:1, 2:1, 3:1, and even 9:1 -- have tended to produce distortion in the distribution of State resources. A typical example which should be eliminated is the disparity in the ratios at which expenditures for the compensation of professional medical personnel is matched under Medicaid. When medical activities are carried on by the "single State agency," usually the State welfare department, State expenditures for the compensation or training of professional medical personnel engaged in the administration of the plan are matched 3 for 1. If the State welfare department contracts with the State health department to provide medical services, the expenditures are matched at a ratio of 1 to 1. The total expenditures for this purpose are small, but the limiting effect upon how the State government shall conduct its affairs is apparent.

The newest experimental and demonstration grant programs and those established to aid in resolving especially critical problems should be at the higher end of the matching scale. But it will be desirable to have the matching revert to a lower ratio after the first few stimulatory years.

Specifically, we recommend the following implementing steps:

(1) The principle of a broad health service formula grant, established under the Partnership in Health Act, should be extended to include the consolidation of other appropriate categorical health grants.[1] If the health services formula grant cannot be so extended, then the States should be authorized to transfer a portion of the funds available for any one category of health services to meet other needs up to an amount approved by the Secretary.

(2) Where project grants are made, up to 20 percent of the total should be made broadly available to improve the administration and provision of basic support services required effectively to undertake the special program, such as laboratories, generalized public health nursing, overall planning and evaluation, and comprehensive health centers.

(3) Greater uniformity should be established in Federal-State matching ratios to reduce in the future the confusion and distortion of programs caused by the wide variations in these ratios.

(4) Using the precedent already set in welfare grants, under which $202 million are made available annually for the administration of welfare activities by State and local governments, HEW should make provision for

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[1] See Section 314(d) "Grants for Comprehensive Public Health Services," PL 89-749.

sharing, on a 1:1 matching basis, the administrative costs of State and local health agencies.[1] HEW should require as a condition to the receipt of such grants for administrative costs, conformance to the objectives and standards of the comprehensive State health plan.

(5) A mechanism should be established to facilitate project grants for developing and providing demonstrations of improved systems of organizing and providing health services (e.g., group practice, contracts with private groups for public services), and for developing of environmental control programs on a "problem shed" basis (including interstate and regional projects).

(6) Finally, we suggest (2) that grants should be used to induce States to establish performance standards, and (b) in evaluating State and local performance such standards be increasingly used as yardsticks of accomplishment (rather than financial accountability alone).

Increasing Health Manpower

A major effort is needed to increase the national pool of skilled health manpower -- doctors, dentists, engineers, nurses, and all types of paramedical personnel. A significant step forward has been taken in the creation within the Public Health Service of a new Bureau of Health Manpower. It should soon play a key role in assessing requirements and encouraging and assisting in the development and utilization of health manpower. The proposed establishment of a "Health Service of the United States" is another basic step forward.

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[1] Estimated Federal share for administrative costs for FY 1967.

We recommend that HEW take the following steps:

(1) Devise for use in health agencies throughout the country, new approaches to the better utilization of the existing limited supply of trained health manpower under the leadership of the new PHS Bureau of Health Manpower. Such approaches would include the use of paramedical personnel in place of physicians; the use of automated techniques to minimize the number of nurses, technicians, and others required; the extension of group practice; and the use of contract relationships to utilize the services of non-governmental professional health personnel in meeting especially urgent needs.

(2) Expand the proposed "Health Service of the United States" (or the Commissioned Corps of the Public Health Service if it is not succeeded by the Health Service) so that qualified officers may be deployed as needed to assignments in any Federal, State, or local agency. This expansion should permit qualified officers of the Health Service to provide needed health services in areas lacking essential health facilities and personnel, even as the National Teacher Corps provides qualified services where children otherwise would be deprived of adequate education.

(3) Make full use of the new Personnel Interchange provisions of PL 89-749 to create a vigorous cadre of health planners and administrators at Federal-State-local levels.[1] The Act broadens the Secretary's authority to detail Federal health workers to State and local governments; it enables the transfer of competent personnel in one community to another in need of assistance; and finally it enhances Federal health planning and administration by bringing in hybrid vigor from those experienced on the firing line.

(4) Encourage State governments to make careers in the public health services more attractive; this will require the provision of competitive salaries, the promotion of occupational and interdisciplinary mobility through planned staff development, and the facilitation of the movement of personnel between Federal, State, and local agencies. The Department's Division of State Merit Systems should extend technical services to local jurisdictions, as well as to States, for improvement of personnel administration and for the development of practical measures to meet these objectives.

(5) Establish a loan program to induce more of this Nation's ablest young people to enter the health professions. Such a loan program should be designed to induce high school, college, and graduate students to undertake training for the health professions, including preparation

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[1] See Section 314(f) "Interchange of Personnel with States," PL 89-749.

to become physicians, engineers, and nurses. The loans made to young people accepting this aid should be forgiven after a service period (five to seven years) in a designated Federal, State, or local health agency.

(6) Expand the vocational and higher education programs to train technical supporting personnel for the health services which are carried on by the Office of Education. In addition, there should be a general expansion of career guidance, student aid, and teacher education programs supported by the Office of Education with appropriate emphasis on the health fields.

(7) Expand the PHS "COSTEP" summer internship program to provide early student exposure and valuable work experience for engineers, physicians, and other professionals who may manifest interest in a career in health work.

(8) Establish a Health Service Education Institute within the Department of Health to provide specialized training (e.g., health planning and administration) not available elsewhere for all members of the National Health Career Service and among State and local health personnel. The training program of the Communicable Disease Center's Epidemic Intelligence Service has done more than any similar effort, within or without the government, to attract young physicians -- and future leaders -- to the health field. This kind of program should be established in other health fields.

(9) Develop and expand the instruction and research in preventive and community health services now offered in many medical schools. The development of such services deserves the same kind of support and emphasis currently given to clinical services.

(10) Establish additional graduate schools of public health. A major part of the need for more trained public health personnel is in the major metropolises; it will be desirable that the additional schools be established in these centers. The existing system of grant support should be revised to keep the present schools at their high level of performance while developing additional schools in major areas where none now exist.

SUMMARY

A number of significant steps need to be taken at the Federal level to strengthen the local-State-Federal health partnership. In particular, there is need for better coordination of Federal health activities, through a Federal Health Agency Council, and for the creation of a new focal point for health, through a subsidiary Department of Health within HEW. These actions will provide better machinery for the exercise of national leadership in health, for the formulation of national health goals, and for the planning necessary to reach these goals.

Federal grants administration needs to be overhauled and simplified. And the Federal Government must develop new approaches to augment the present supply of professional health manpower. The new

Partnership in Health legislation offers an opportunity not only for the establishment of needed comprehensive health planning at Federal, State, and local levels, but also a beginning stimulus for reform of Federal grant-in-aid mechanisms, as well as a start toward better utilization of health manpower.

The delivery of health services depends on strong, viable health agencies at State and local levels. The actions recommended in this chapter will help toward this end.

The recommendations of this Committee are designed to clarify the roles of local, State, and Federal health agencies and to simplify and improve the relationships among them. The health of the people depends on a structure that is flexible, creative, and responsive to human needs. The purpose of this Report is to help build such a structure. If today's challenges and opportunities are to be met, the total health structure must develop a unity of purpose, expand its horizons, and bring forth vigorous new leadership.

CONCLUSIONS AND RECOMMENDATIONS

Strengthening the Local Health Partner

		Page
1.	Local governmental units, to cope with today's health problems, must be consolidated or effectively interrelated in a joint effort, that establishes a governmental service area coterminous with the health problem area.	43
2.	A health planning council should be established to assess local needs, to hear citizens' views, and to formulate plans in all local areas sufficiently large to cope effectively with health problems.	45
3.	A community health plan should provide a full range of personal health services for all people and such environmental health services as are susceptible to solution on a community-wide basis; this plan should include: a system for coordinating and integrating health services, the optimum geographic distribution of facilities, the establishment of neighborhood service and comprehensive health care centers, the conduct of health education programs and experimental projects, and the application of improved methods for controlling medical costs.	49
4.	HEW should initiate a major program to educate the public about health; support should be made available to finance educational demonstrations aimed at communicating health information in selected metropolitan areas and rural areas of special need.	55
5.	Local health departments must be strengthened - in attitude and in competence - to provide staff assistance, leadership, and stimulation for each Health Planning Council.	58
6.	The State health agency should see to it that an effective planning process exists for each local community, should aid local communities in developing their plans, should develop minimum standards for the organization and operation of local health services, and should require that local public health services become operative in all parts of the State.	61

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7. Where a State is unable or unwilling to assist in providing health services in urban areas, the urban governments should be free to deal directly with HEW. 62

8. HEW should seek statutory authority, adequate manpower, and funds that would enable it to respond to requests from State or local governments, when they are confronted with emergencies growing out of critical unmet health care needs. 63

9. For those areas where the assurance of basic health care is beyond the capability of the local health agency, and where the State is unwilling or unable to fill the gap, direct Federal aid should be provided. This aid should take the form either of the assignment of personnel for limited periods, or the provision of facilities, or both. 64

10. Legislation should be sought authorizing the Public Health Service, Veterans Administration, and Department of Defense to make their health facilities available on a reimbursable basis when they are not otherwise fully utilized to meet State and community needs; and further authorizing them to contract for the use of local health services for their beneficiaries where these are available.

    Demonstrations should be undertaken in a few communities where Federal health installations are located to make manifest the feasibility of such reciprocal utilization of facilities. 65

Strengthening the State Health Partner

11. Each State should formulate health objectives and carry out comprehensive planning for health services to meet the needs of all its people. The health objectives should be considered by the Governor and submitted to the Legislature for approval and enunciation as a declaration of State health policy. 72

12. The Department of Health, Education, and Welfare should develop national health goals, and within the limitations of these broad goals should allow the States maximum flexibility

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to develop their health plans; once such health plan is in effect, HEW should require conformity with the established objectives and priorities as a condition to the receipt of both health services and facilities grants. 74

13. A State health planning council should be established in each State to help set goals, plan programs, determine priorities, and allocate resources, including interrelation of programs for hospital construction; heart, cancer, and stroke; mental health and retardation; and other relevant activities. 75

14. There should be a strong health department capable of giving leadership and direction to the total health effort in each State. Model legislation should be prepared to guide States in developing such departments. 76

15. The growing demands of health programs make it essential that a permanent and well financed planning, development, and evaluation unit be an integral part of the State health department. 78

16. There should be a responsible State health officer appointed by and serving at the pleasure of the Governor in each State. 79

17. State health agencies should broaden their partnership with all the health resources in the State, including medical and other professional schools; a wide variety of groups should be involved in State health planning and in developing a comprehensive system of personal and environmental health services. 80

18. HEW should seek amendment to the Medicaid program (Title XIX) to make specific the State health agency responsible for the health aspects of this program (health goals, scope of medical benefits, standards, relationships with providers of health care, utilization control, and evaluation). 82

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19. The "single State agency" requirement should be modified in order to allow States to combine the skills and resources of several agencies into a coordinated State effort, subject to the approval of the alternate arrangement by the Secretary of HEW. 84

20. The Governors and their health agencies should initiate and negotiate interstate compacts and other cooperative arrangements with neighboring States in order that effective action may be brought to bear upon health problems affecting interstate areas. HEW should encourage such interstate cooperation and render financial support to the health programs of interstate agencies. Legislation should be sought from the Congress granting advanced consent to interstate compacts for the purpose of public health planning and health education. 86

Strengthening the Federal Health Partner

21. The Department of Health, Education, and Welfare must develop its capability for formulating national health goals specific in nature, clear in statement, and including a plan of sequential steps and a schedule to guide implementation; these goals should be considered by the President and submitted to the Congress for approval and enunciation as a declaration of National health policy. 90

22. HEW should provide ample resources for research and stimulate demonstrations to devise new systems and methods for the delivery of health services to people. 92

23. A stronger and better integrated organizational focus for health activities of the Federal Government must be created; this should take the form of a subsidiary "Department of Health" within the Department of Health, Education, and Welfare. 93

24. Within the proposed subsidiary Department of Health, greater provision should be made for leadership and for funding in the field of environmental health than is now apparent. 96

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25. A Federal Interagency Health Council should be established to better coordinate health activities among Federal agencies; the Council should consist of the head (or deputy head) of each of the agencies with sizable health programs and should meet regularly under the chairmanship of the proposed new Secretary of Health. 98

26. OEO health demonstration projects should be transferred to HEW administration after they have proven their worth by three to five years of successful operation. 99

27. HEW should take steps to develop stronger Regional Offices. Substantially greater authority for coordination and decision making should be delegated to the HEW Regional Directors; each Regional Director in turn should be able to depend upon specialists for assistance in the direction and coordination of activities within each region. 100

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(3) A firm practice be initiated by the Secretary of HEW that neither he nor the commissioners of HEW agencies will act on requests from State or local governmental officials without consulting with the Regional Director.

(4) The Regional Director be directed to plan and make regular visits with Governors and with the mayors of major cities to discuss relevant HEW activities,

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including health matters, so that the Governors and mayors may develop fuller confidence in the Regional Directors, and may be expected to deal with them first more often than in the past.

(5) Contingency funds be provided so that each Regional Director (without approval of specific actions at headquarters) may assist States in emergencies and may stimulate innovative projects.

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(2) Where project grants are made, up to 20 percent of the total should be made broadly available to improve the administration and provision of basic support services required effectively to undertake the special program, such as laboratories, generalized public health nursing, overall planning and evaluation, and comprehensive health centers.

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(5) A mechanism should be established to facilitate project grants for developing and providing demonstrations of improved systems of organizing and providing health services (e.g., group practice, contracts with private groups for public service), and for development of environmental control programs on a "problem shed" basis (including interstate and regional projects).

(6) Finally, we suggest (a) that grants be used to induce States to establish performance standards, and (b) in evaluating State and local performance, such standards be increasingly used as yardsticks of accomplishment (rather than financial accountability alone).

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(2) Expand the proposed "Health Service of the United States" (or the Commissioned Corps of the Public Health Service if it is not succeeded by the Health Service) so that qualified officers may be deployed as needed to assignments in any Federal, State, or local agency. This expansion should permit qualified officers of the Health Service to provide needed health services in areas lacking essential health facilities and personnel, even as the National Teacher Corps provides qualified services where children otherwise would be deprived of adequate education.

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(4) Encourage State governments to make careers in the public health services more attractive; this will require the provision of competitive salaries, the promotion of occupational and interdisciplinary mobility through planned staff development, and the facilitation of the movement of personnel between Federal, State, and local agencies. The Department's Division of State Merit Systems should extend technical services to local jurisdictions, as well as to States, for improvement of personnel administration and for the development of practical measures to meet these objectives.

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(6) Expand the vocational and higher education programs to train technical supporting personnel for the health services which are carried on by the Office of Education. In addition, there should be a general expansion of career guidance, student aid, and teacher education programs supported by the Office of Education with appropriate emphasis on the health fields.

(7) Expand the PHS "COSTEP" summer internship program to provide early student exposure and valuable work experience for engineers, physicians, and other professionals who may manifest interest in a career in health work.

(8) Establish a Health Service Education Institute within the Department of Health to provide specialized training (e.g., health planning and administration) not available elsewhere for all members of the National Health Career Service and among State and local health personnel. The training program of the Communicable Disease Center's Epidemic Intelligence Service has done more than any similar effort, within or without the government, to attract young physicians -- and future leaders -- to the health field. This kind of program should be established in other health fields.

(9) Develop and expand the instruction and research in preventive and community health services now offered in many medical schools. The development of such services deserves the same kind of support and emphasis currently given to clinical services.

(10) Establish additional graduate schools of public health. A major part of the need for more trained public health personnel is in the major metropolises; it will be desirable that the additional schools be established in these centers. The existing system of grant support should be revised to keep the present schools at their high level of performance while developing additional schools in major areas where none now exist.

Appendix A

Secretary's Advisory Committee on HEW Relationships with State Health Agencies

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Dr. William J. Peeples, Commissioner of Public Health, Maryland Department of Health, Baltimore, Maryland

Mr. Edmund F. Ricketts, Lecturer in Government, Miami University, Oxford, Ohio

Dr. Harold M. Visotsky, Director, State Department of Mental Health, Chicago, Illinois

Mr. Paul D. Ward, Health and Welfare Administrator, State of California, Sacramento, California

Dr. Alonzo S. Yerby, Professor and Head, Department of Health Services Administration, Harvard School of Public Health, Boston, Massachusetts

Staff and Task Force Members

Staff Director

Dr. P. Walton Purdom, Director of Graduate Program in Environmental Engineering and Science, Drexel Institute of Technology, Philadelphia, Pennsylvania

Staff Associate

Dr. Frederick Nevins, Sanitary Engineer Director, Office of the Chief, Division of Environmental Engineering and Food Protection, Public Health Service

Task Force Members

Food and Drug Administration

Mr. J. K. Kirk, Assistant Commissioner for Operations

Mr. Bill V. McFarland, Deputy Director, Office of Federal-State Relations

Office of Economic Opportunity

Mrs. Ruth Hanft, Program Analyst, Health Division, Community Action Program

Office of Education

Mr. John R. Ludington, Deputy Associate Commissioner, Bureau of Adult and Vocational Education

Miss Helen K. Powers, Chief, Health Occupations Unit, Division of Vocational and Technical Education, Bureau of Adult and Vocational Education

Public Health Service

Dr. Eugene H. Guthrie, Assistant Surgeon General for Operations

Mr. William M. Hiscock, Deputy Chief, Division of Public Health Methods, Office of the Surgeon General

Social Security Administration

Mr. Karl W. Bredenberg, Deputy Assistant Commissioner, Field

Mr. Roger J. Cumming, Deputy Director, Community Services Staff, Office of the Commissioner

3

Vocational Rehabilitation Administration

Mr. Joseph Hunt, Assistant Commissioner
for Program Services

Welfare Administration

Mr. John J. Hurley, Deputy Director,
Bureau of Family Services

Dr. Arthur J. Lesser, Deputy Chief,
Children's Bureau

Appendix B

Agencies and Professional Organizations Contacted

American Academy of General Practice
American Association for Hospital Planning
American Association for Maternal and Child Health
American Association for Rehabilitation Therapy
American Association of Homes for the Aging
American Association of Medical Clinics
American Association of Poison Control Centers
American Cancer Society
American College Health Association
American College of Apothecaries
American College of Hospital Administrators
American Dental Association
American Diabetes Association
American Dietetic Association
American Geriatrics Society
American Heart Association
American Hospital Association
American Industrial Hygiene Association
American Institute of Architects
American Medical Association
American Nurses' Association
American Nursing Home Association
American Pharmaceutical Association
American Psychiatric Association
American Psychological Association
American Public Health Association
American Public Welfare Association
American School Health Association
American Society for Public Administration
American Society of Planning Officials
American Standards Association
American Veterinary Medical Association
American Water Works Association
Association for Physical and Mental Rehabilitation
Association for the Aid of Crippled Children
Association of American Medical Colleges
Association of Food and Drug Officials of the U.S.

Association of Rehabilitation Centers
Association of State and Territorial Health Officers
Blue Cross Association
Conference of State and Territorial Hospital and Medical
  Facilities and Survey Construction Authorities
Conference of State and Territorial Mental Health Authorities
Council of Social Work Education
Council of State Administrators of Vocational Rehabilitation
Council of State Governments
Federation of State Medical Boards of the United States
Group Health Association of America
Joint Council to Improve the Health Care of the Aging
National Academy of Sciences--National Research Council
National Association for Mental Health
National Association of Blue Shield Plans
National Association of Boards of Pharmacy
National Association of Sanitarians
National Association of Social Workers
National Association of State Departments of Agriculture
National Conference on Social Welfare
National Council of State Public Welfare Administrators
National Council on Aging
National Education Association
National Health Council
National Health Education Committee
National League for Nursing
National Medical Association
National Rehabilitation Association
National Safety Council
National Social Welfare Assembly
National Society for Crippled Children and Adults
National Tuberculosis Association
The National Foundation
United Community Funds and Councils of America

Association Contacts

Mr. Noble J. Swearingen
Director, Washington Office
American Public Health Association

On November 4, 1966, members of the Advisory Committee met with the following Directors of the American Public Health Association and the Association of State and Territorial Health Officers:

- Dr. Ernest L. Stebbins
- Dr. Lester Breslow
- Dr. Bernard Bucove
- Dr. John Hanlon
- Dr. George James
- Dr. Berwyn F. Mattison
- Dr. Cecil Sheps
- Dr. Milton Terris
- Dr. Myron E. Wegman

Appendix C

Officials of the Federal Government Consulted by the Advisory Committee or Its Representatives

Department of Health, Education, and Welfare

Mr. Dean W. Coston, Deputy Under Secretary
Dr. Philip R. Lee, Assistant Secretary for Health and Scientific Affairs
Dr. George A. Silver, Deputy Assistant Secretary for Health and Scientific Affairs
Mr. Donald F. Simpson, Assistant Secretary for Administration
Mr. John D. R. Cole, Deputy Assistant Secretary for Administration
Mr. Edmund Baxter, Director, Office of Field Coordination
Mr. James C. Callison, Field Administration Representative, Office of Field Coordination
Mr. Albert Henry Aronson, Director, Division of State Merit Systems

Public Health Service

Dr. William H. Stewart, Surgeon General
Dr. Leo J. Gehrig, Deputy Surgeon General
Dr. Eugene H. Guthrie, Assistant Surgeon General for Operations
Mr. M. Allen Pond, Assistant Surgeon General for Plans
Mr. Albert H. Stevenson, Chief Sanitary Engineering Officer
Mr. J. Robert Painter, Representative for PHS Regional Activities
Dr. William L. Kissick, Chief, Division of Public Health Methods
Mr. William M. Hiscock, Deputy Chief, Division of Public Health Methods

Bureau of Medical Services

Dr. Carruth J. Wagner, Chief
Dr. Andrew P. Sackett, Deputy Chief
Mr. Jerrold M. Michael, Associate Chief for Program
Mr. Saul R. Rosoff, Executive Officer
Dr. Kazumi Kasuga, Deputy Chief, Division of Indian Health

Bureau of State Services

Dr. Richard A. Prindle, Chief
Dr. Paul O. Peterson, Acting Deputy Chief
Dr. Philip Broughton, Consultant, Office of the Bureau Chief
Mr. Hershel Engler, Special Assistant to the Bureau Chief for Regional Office Liaison
Miss Evelyn Flook, Chief, Research Grants Branch, Division of Community Health Services
Dr. Joseph A. Gallagher, Deputy Chief, Division of Hospital and Medical Facilities
Mr. Wesley Gilbertson, Chief, Office of Solid Wastes
Mr. Malcolm C. Hope, Acting Chief, Division of Environmental Engineering and Food Protection
Mr. Vernon G. MacKenzie, Chief, Division of Air Pollution
Dr. James D. Wharton, Chief, Division of Community Health Services
Mr. Earl O. Wright, Chief, Office of Grants Management

Division of Regional Medical Programs, National Institutes of Health

Dr. Robert Q. Marston, Chief
Mr. Stephen J. Ackerman, Chief, Planning and Evaluation Branch

National Institute of Mental Health

Dr. Stanley F. Yolles, Director
Dr. Phillip L. Sirotkin, Deputy Director
Mr. George M. Kingman, Assistant Executive Officer

Food and Drug Administration

Dr. James L. Goddard, Commissioner
Mr. Winston B. Rankin, Deputy Commissioner
Mr. James C. Pearson, Director, Office of Federal-State Relations
Mr. Bill V. McFarland, Deputy Director, Office of Federal-State Relations
Mr. Glenn W. Kilpatrick, Office of Federal-State Relations
Mr. Frank D. Clark, Deputy Director, Bureau of Education and Voluntary Compliance

Social Security Administration

Mr. Robert M. Ball, Commissioner
Miss Neota Larson,* Director, Community Services Staff, Office of the Commissioner
Mr. Roger J. Cumming, Deputy Director, Community Services Staff, Office of the Commissioner
Mr. Arthur E. Hess, Director, Bureau of Health Insurance
Mr. Bernard Popick, Director, Bureau of Disability Insurance

Vocational Rehabilitation Administration

Miss Mary E. Switzer, Commissioner
Mr. Joseph Hunt, Assistant Commissioner for Program Services
Mr. James F. Garrett, Assistant Commissioner for Research and Training
Mr. Thomas J. Skelley, Chief, Division of Disability Services

Welfare Administration

Dr. Ellen Winston, Commissioner

Bureau of Family Services

Mr. Fred H. Steininger, Director
Mr. John J. Hurley, Deputy Director
Mr. Carel E. H. Mulder, Assistant Chief, Division of Medical Services

Children's Bureau

Mrs. Katherine B. Oettinger, Chief
Dr. Arthur J. Lesser, Deputy Chief
Dr. Louis Spekter, Director, Division of Health Services
Mr. Ralph Pardee, Assistant Chief, Administrative Methods Branch

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*Deceased

DHEW Region I, Boston, Massachusetts

Mr. Walter W. Mode, Regional Director
Dr. Mabel Ross, Regional Health Director
Dr. Harriet Felton, Children's Bureau Representative
Mr. Frank Tetzlaff, Associate Regional Health Director

DHEW Region IV, Atlanta, Georgia

Mr. William J. Page, Jr., Regional Director
Dr. Hugh Cottrell, Regional Health Director
Dr. John Thomas Leslie, Regional Medical Director, Children's Bureau

DHEW Region IX, San Francisco, California

Dr. R. Leslie Smith, Regional Health Director

Communicable Disease Center, PHS, Atlanta, Georgia

Dr. David J. Sencer, Chief
Dr. John R. Bagby, Deputy Chief
Mr. Bill Watson, Executive Officer

Bureau of the Budget

Mr. Irving Lewis, Chief, Division of Health and Welfare
Mr. Mark Alger, Division of Health and Welfare
Mr. Walter Smith, Division of Health and Welfare
Mr. Milton Turen, Division of Health and Welfare

Department of Housing and Urban Development

Mr. Ralph Taylor, Assistant Secretary for Intergovernmental Relations
Mr. Richard Gerson, Acting Director, Urban Policy Coordination

Office of Economic Opportunity

Miss Lisbeth Bamberger, Assistant Director, Health Division, Community Action Program
Mrs. Ruth Hanft, Program Analyst, Health Division, Community Action Program

Rogers' Subcommittee on Investigation of the Department of Health, Education, and Welfare, Committee on Interstate and Foreign Commerce, U. S. House of Representatives

Mr. Jonathan W. Sloat, Chief Counsel
Mr. Norman E. Holly, Chief Economist
Mr. Daniel J. Manelli, Attorney

Appendix D

Officials of State Governments Consulted by Members or Representatives of the Advisory Committee

Arkansas

Honorable Orval E. Faubus, Governor
Mr. Clarence C. Thornborough, Secretary to the Governor
Dr. J. T. Herron, State Health Officer
Dr. Edgar J. Easley, Assistant State Health Officer and Director, Bureau of Local Health Services
Mr. Marvin L. Wood, Director, State Water Pollution Control Commission
Mrs. Lucy Uterbock, Secretary and Director, State Cancer Commission
Mr. A. W. Ford, Commissioner of Education
Mr. E. Russell Baxter, Director, Arkansas Rehabilitation Service
Mr. A. J. Moss, Commissioner of Welfare

California

Honorable Edmund G. Brown, Governor
Mr. Paul D. Ward, Health and Welfare Administration
Dr. Lester Breslow, Director of Public Health
Mr. Frank M. Stead, Chief, Division of Environmental Sanitation
Mr. James W. Bell, Chief, Bureau of Food and Drug Inspections, Division of Environmental Sanitation
Mr. John A. Maga, Chief, Bureau of Air Sanitation, Division of Environmental Sanitation
Dr. John M. Heslep, Bureau of Radiological Health, Division of Environmental Sanitation
Dr. Saylor, Waste Management Project, Division of Environmental Sanitation
Dr. Theodore Montgomery, Assistant Chief, Division of Preventive Medical Services
Mr. John R. Derry, Chief, Bureau of Hospitals, Division of Preventive Medical Services
Dr. Robert R. Johnson, Acting Chief, Bureau of Occupational Health, Division of Preventive Medical Services
Dr. Charles R. Gardipee, Chief, Bureau of Crippled Children Services, Division of Preventive Medical Services
Mr. Barnes, Division of Preventive Medical Services

California

Mr. Kirkpatrick, Division of Preventive Medical Services
Dr. William A. Longshore, Jr., Chief, Division of Community Health Services
Dr. James T. Harrison, Assistant Chief, Division of Community Health Services
Dr. C. Henry Murphy, Regional Medical Coordinator, Division of Community Health Services
Mr. Robert G. Webster, Chief, Division of Administration
Dr. James V. Lowry, Director, State Department of Mental Hygiene
Mr. Warren Thompson, Director, State Department of Rehabilitation
Mr. J. M. Wedemeyer, Director, State Department of Social Welfare
Mr. Fernando Torgeson, Health and Medical Care
Dr. Harry Brickman, Director, Los Angeles County Department of Mental Health
Dr. Donald Schwartz, Deputy Director, Los Angeles County Department of Mental Health
Mr. William A. Barr, Superintendent of Charities, Los Angeles County
Dr. John E. Affeldt, Medical Director, Department of Charities, Los Angeles County
Dr. Harold D. Chope, Director of Public Health and Welfare, San Mateo County
Dr. Henrik Blum, Health Officer, Contra Costa County

Connecticut

Honorable John Dempsey, Governor
Dr. Franklin M. Foote, Commissioner of Health
Dr. Harold S. Barrett, Deputy Commissioner of Health
Dr. Wilfred Bloomberg, Commissioner, State Department of Mental Health
Mr. John F. Harder, Deputy Commissioner, Department of Welfare
Dr. Ryan, Medical Division, Department of Welfare
Dr. James S. Peters, Director, Division of Vocational Rehabilitation
Mr. Attilio R. Frassinelli, Commissioner, State Department of Consumer Protection

Connecticut

Mr. Herbert P. Plank, Chief, Drug Division, State Department of Consumer Protection
Mr. Raymond L. Dunn, Director, Pharmacy Division, State Department of Consumer Protection
Mr. George J. Conkling, Commissioner, State Department of Finance and Control

Georgia

Honorable Carl E. Sanders, Governor
Mr. Frank C. Smith, Director, Office of Administration
Mr. Rufus F. Davis, Budget Officer
Dr. John H. Venable, Director, Department of Public Health
Dr. Elton S. Osborne, Deputy Director, Department of Public Health
Dr. Addison M. Duval, Director, Division of Mental Health
Miss Diane C. Stephenson, Project Officer
Mr. James M. Sitten, Director, Medical Facilities Branch
Dr. Oscar F. Whitman, Director, Office of Local Health
Mr. Raymond Summerlin, Director, Food Division, State Department of Agriculture
Mr. Frank Stancil, State Department of Agriculture
Mr. McCullom, State Department of Education
Dr. T. O. Vinson, Health Officer, DeKalb and Rockdale Counties, Decatur, Georgia
Mr. A. P. Jarrell, Office of Rehabilitation, Milledgeville, Georgia
Mr. John Prickett, Office of Rehabilitation, Milledgeville, Georgia
Mr. J. L. Hise, Office of Rehabilitation, Milledgeville, Georgia
Mr. Wallace Petty, Office of Rehabilitation, Milledgeville, Georgia
Mr. W. A. Crump, Office of Rehabilitation, Milledgeville, Georgia

Idaho

Honorable Robert E. Smylie, Governor
Mr. Robert McCall, Assistant to the Governor
Dr. Terrell O. Carver, Administrator of Health
Dr. F. O. Graeber, Deputy Administrator of Health
Mr. Richard Adams, Director, Hospital Facilities Division
Mr. Jack Steneck, Director, Community Mental Health Division
Mr. Vaughn Anderson, Director, Engineering and Sanitation Division
Dr. John Marks, Chief, Maternal and Child Health Section and Superintendent, Idaho State School and Hospital

Idaho

Mr. Lloyd Young, Director, Vocational Rehabilitation Service
Mr. William Child, Commissioner, Department of Public Assistance

Iowa

Honorable Harold E. Hughes, Governor
Dr. Arthur P. Long, Commissioner of Public Health
Mr. Paul H. Crews, Secretary, Pharmacy and Narcotics Board
Mr. Arthur Downing, Chairman, Social Welfare
Mr. Ross Wilbur, Director, Division of Family and Children Services
Dr. John C. MacQueen, Director, State Services for Crippled Children
Dr. Sidney S. Kripke, Assistant Director, State Services for Crippled Children
Mr. Jerry Starkweather, Director, Vocational Rehabilitation
Dr. James Cromwell, Mental Health Board of Control
Mr. Verne Kelley, Mental Health Authority

Maryland

Honorable J. Millard Tawes, Governor
Mr. Henry G. Bosz, State Department of Budget and Procurement
Dr. William J. Peeples, Commissioner, State Department of Health
Mr. Clemens W. Gaines, Assistant Commissioner for Administration
Mr. Francis S. Balassone, Chief, Division of Drug Control, State Department of Health
Dr. Isadore Tuerk, Commissioner, State Department of Mental Hygiene
Mr. Raleigh C. Hobson, Director, State Department of Public Welfare
Mr. Dennis A. Alessi, Staff Specialist, Maryland State Planning Board
Mr. R. Kenneth Barnes, Assistant State Superintendent, State Department of Education, Division of Vocational Rehabilitation
Mr. Merl D. Myers, Division of Vocational Rehabilitation
Mr. J. Leo Delaney, Division of Vocational Rehabilitation
Mr. Robert L. Burton, Division of Vocational Rehabilitation

Michigan

Honorable George Romney, Governor
Mr. Herb DeJonge, Administrative Assistant to Governor Romney
Dr. Albert E. Heustis, State Health Commissioner
Dr. John L. Isbister, Chief, Bureau of Community Health
Dr. G. D. Cummings, Director of Laboratories
Mr. Bernard Bloomfield, Occupational Health Division
Mr. Edwin Rice, Consultant, Health, Physical Education, and Recreation, Department of Education
Dr. R. Gerald Rice, Director, Michigan State Crippled Children's Commission
Mr. Bernard Houston, Director, Department of Social Services
Dr. Robert A. Kimmich, Director, Department of Mental Health
Mr. Ralf A. Peckham, Assistant Superintendent, Vocational Rehabilitation, Department of Education

Pennsylvania

Honorable William W. Scranton, Governor
Mr. McHugh Brackbill, Budget Secretary
Dr. Charles L. Wilbar, Secretary of Health
Mr. Charles L. Eby, Director of Vocational Rehabilitation
Mr. Max Rosenn, Secretary of Public Welfare
Mr. L. H. Bull, Secretary of Agriculture
Dr. Joseph Wunsch, Regional Medical Director, Region VI, West Reading, Pennsylvania
Dr. Norman R. Ingraham, Health Commissioner, City of Philadelphia
Dr. Lear, Health Department, City of Philadelphia
Dr. Polk, Health Department, City of Philadelphia
Mr. Jackson, Health Department, City of Philadelphia
Mr. Randolph E. Wise, Director of Public Welfare, City of Philadelphia

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